United States Court of Appeals

for the Second Circuit

JOINT APPENDIX

76-7249

UNITED STATES COURT OF APPEALS

For The Second Circuit

Docket No. 76-7249

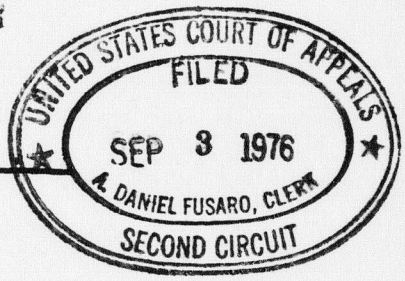
ANNA R. JOHNSON and ROBERT K. JOHNSON

Plaintiffs-Appellants

-against-

PHILLIP KNAPP

Defendant-Appellee



JOINT APPENDIX

VOLUME II

(Pages 331-702)

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Q Dr. Yannuzzi, are you a physician and surgeon duly licensed to practice in the State of New York?

A Yes.

Q When were you so licensed?

A I think it was 1966 or '67.

Q Would you tell the court and jury your educational pre-medical and medical education?

A Harvard College, Boston University Medical School, internship University Hospital Boston, Manhattan Eye and Ear Residency Hospital, chief of residency, director of residency training for five years at Manhattan Eye and Ear Hospital, division of Cornell University Medical Center.

Presently director of argon laser laboratory, fluorescein angiography services, attending surgeon at the same hospitals.

Q Doctor, are you board certified in the field of ophthalmology?

A Yes.

Q Have you specialized in any sub-area of ophthalmology?

A My main interest is in the macula, which is a portion of the retina. But I do do all of ophthalmology.

Q Doctor, have you published or had published any papers, articles, books, in the area of ophthalmology or

in your sub-area of specialization?

A Numerous articles, chapters, a co-author of a book on fluorescein angiography in press, and a book in preparation on the macula.

Q Doctor, did I ask you to look at some records in the case of Anna Johnson?

A Yes.

Q Doctor, when for the first time did you meet me?

A Last week.

Q Doctor, based upon your review of those records, do you have any opinion with respect to the condition and/or conditions that Mrs. Johnson suffered from following cataract surgery in 1972?

MR. RHEINGOLD: Objected to, your Honor. I have no way of knowing what records the witness based his testimony upon.

THE COURT: I think he should identify the records that he reviewed.

Q Doctor, would you specify what records were presented to you for your review prior to testifying here today?

A The notes of Drs. Knapp and Coleman, the notes of Dr. Marvin Sears at Grace Yale-New Haven, and the

deposition of Dr. Sears.

Q Did you see any fluorescein angiography slides and slides with reference to this patient?

A Yes.

Q Did you see portions of the Yale-New Haven Hospital record?

A Yes.

Q Did you see the Columbia Presbyterian Hospital record?

A Yes.

Q Doctor, based upon all of those records that you reviewed, did you come to any conclusions and/or opinions with respect to the condition and/or conditions that Mrs. Johnson suffered from following October of 1972?

A Yes.

Q Doctor, what condition and/or conditions did she suffer from?

A Postoperatively she developed cystoid macular edema and intraocular inflammation. Ultimately changes in her cornea, which led to subsequent surgery.

Q Doctor, what is cystoid macular edema?

A Cystoid macular edema is edema or swelling or fluid accumulation in the portion of the retina, the macula, that can and does reduce vision. Thre are many,

many implications and factors related to it, its onset, its incidence, its natural course, its response to a variety of treatments that are disappointing.

Specifically you can expand upon those.

THE COURT: What does the word cystoid as used in that context denote?

THE WITNESS: It means more for logically the characteristic pattern that's produced by the accumulation of fluid. It really has no other basis biologically.

Q What is the source of the fluid that is characteristic of cystoid macular edema?

A The fluid that accumulates in this cyst or cystoid pattern comes from the capillaries of the retina and accumulates in the macular region.

Q What type of fluid is this from the capillaries? Is it blood or is it --

A This is clear fluid from the bloodstream.

Q Is there clear fuild commonly in the capillaries of the bloodstream?

A Potentially, yes.

Q Doctor, what are the causes of cystoid macular edema?

A The specific causes are unknown. It is related to many intraocular phenomena. One of them is following

any form of surgery, particularly cataract surgery where it is extremely common. There are many other causes in eyes that have not been operated on. Diabetes, for example, is a cause. Any retinal vascular diseases where there is occlusion of a retinal vessel. Thrombosis or an occlusion of an isolated vessel in someone who has hypertension or who is otherwise systemically normal may produce this. toxisties with medications may product it. Radiation, freezing or burning of the eye may product it. Many others.

Q Doctor, is the appearance or occurrence of cystoid macular edema related in any way to a surgical mishap in the course of removing a cataract or cataracts?

A Classically this condition appears following uneventful surgery and it appears rather commonly, anywhere from 40 to 70 per cent in incident studies. In my own personal incident study, it occurred about 60 per cent.

Q You say uneventful surgery. Could you expand on that?

A By that I mean in the course of the surgical treatment, nothing specifically occurred that was not planned in the removal surgery. Nothing that would have disappointed the surgeon in his programmed or planned

approach to the removal of the cataract. There are certain things in the course of removing a cataract that are sometimes unavoidable. Even these factors when they occur are not necessarily and are not associated specifically with the onset of this condition.

Q Is there any time element or time period within which cystoid macular edema can or does occur in the post-operative cataract patient?

A Well, we are studying this right now, and we have a paper which will appear shortly in the American Journal of Ophthalmology on its onset early and immediately following cataract surgery, and very often it does not appear right after the procedure itself. It usually takes weeks, months or even years. A tremendous variability in its onset.

Q Doctor, what are the characteristics of the development of cystoid macular edema?

A The typical course -- and we are speaking in particular because of this case with cystoid macular edema that may be seen in association with cataract surgery -- typically there is a good response following treatment, uneventful surgery, the corrected vision is good, and many weeks later or months later or even years later the vision begins to deteriorate, there is some intraocular

evidence of inflammation, and the angiogram is confirmatory in that it shows accumulation of fluid within the retina in these characteristic cystoid spaces in the macula.

Q Is inflammation, then, a characteristic in some manner or form of cystoid macular edema?

A Yes.

Q Doctor, based upon your review of the records in this case, was there inflammation found with respect to Mrs. Johnson in the postoperative period?

A At first there was a trace, which is typical of any surgery. Then there was no evidence of inflammation in the first eye that was operated on, and then inflammation became apparent in both eyes.

Q Do you recall the date that the inflammation became apparent, Doctor?

A In both eyes?

Q Yes.

A I think that was in January when there was also a coincidental reduction in vision. In December of that year, the month preceding, the corrected vision in the first eye was extremely good, and there was no evidence of inflammation, which is typical.

Q Doctor, based upon the good corrected vision or the good vision in the first operated eye in December,

what was the significance of that?

A Well, in reference to this particular case, the status of the first operated eye, the left eye, in December with no evident inflammation, with good corrected vision and no evidence of any abnormality, it would indicate to one, the surgeon and the patient, in a patient who is considering bilateral surgery, to proceed with the other eye. In this particular case the other eye had already been done anyway.

Q Doctor, based upon your review of the records, the second eye was done during the first hospital admission of this patient some seven days following the first extraction. Was there any contraindication based upon your review of the records to proceeding with the second eye during that admission?

A No.

Q Doctor, are you familiar with the practice in this community in 1972 with respect to bilateral contract extraction during the same hospital admission of a patient?

A Yes.

Q What was that practice?

A Well, it was and still is in approximately 25 per cent of the patients admitted to the Manhattan Eye and Ear Hospital, they are admitted with the plan to do both eyes

during the same admission. In our particular practice, if that's of interest to you, about 30 to 40 per cent of our patients collectively, and I work in a group with three people, about 30 to 40 per cent of our patients are scheduled to have bilateral cataract surgery a week apart, depending upon the factors in the individual patient and the vision, other factors. But overall, about 30 to 40 per cent.

Q Doctor, do the figures with respect to other ophthalmologists and other institutions in this community vary from that 25 per cent at Manhattan Eye and Ear and your own 30 to 40 per cent?

A Widely. Not only in the community, but at our hospital. Some doctors do this more commonly, others do it less commonly.

Q Is it a matter of surgical and/or professional judgment on the part of the physician whether to do or not to do bilateral extractions during the same admission?

A Absolutely.

Q Doctor, does the time period with respect to bilateral extractions vary?

A Yes.

Q Do some surgeons in this community do the second operation approximately three days following the first

operation?

A I would say approximately five to seven days is the typical. On a single admission, not after seven at our hospital.

Q In other words, the patient could not remain in the hospital for more than seven days?

A Without having the other eye scheduled.

Q Without having the second operation performed, is that correct?

A Again, it varies. If there is a problem with the patient or systemically or if there is some question as to whether to proceed, but five to seven days is the typical guideline.

Q Are there any benefits to a patient to bilateral cataract extraction during the same admission?

A Yes.

Q Could you enumerate some of those benefits?

A The benefits lie in -- they again come back down to the individual, his eye and to the doctor's preference. Usually the consideration is to eliminate two periods of convalescence for one. Also to eliminate the state of monocular afagia in appropriate patients, and this is a concept that is difficult for patients to understand and I am sure the jury may not understand it, but when one has

had a cataract removed in one eye, that produces a state of monocular absence of the lens. A cataract is removal of the lens. To use that eye with his fellow eye is not possible with a spectacle. In order to bring the image size differences close in both eyes so that both eyes can be used together binocularly, a contact lens is necessarily employed.

The use of a contact lens to correct monocular afagia is very problematical. It is at best only successful in about 20 per cent of the patients, then and even now, in a day when lenses have been improved.

So in order to provide binocular vision for one who needs it and who wants it, bilateral surgery is contemplated.

Q Doctor, the failure factor with respect to contact lenses is based on what?

A It is based on the patient, his motivation, his emotional and physical capability. One who has a tremor or who does not have good dexterity is not a good candidate. One who is emotionally very labile or anxious is not a good patient. One who has a low threshhold to sensivity and discomfort is not.

Q Are all of those factors or should all of those factors with respect to a patient be taken into consideration

when contemplating either monocular or binocular cataract extraction?

A This is where science of medicine differentiates from the art of medicine. The doctor is required to artistically judge based on his experience and his understanding of the patient whether or not he will be a good candidate.

Q Doctor, is the average person who has some form of vision in both eyes a person who is used to binocular vision?

A Yes. These are the people who need binocular vision more. People who have never experienced binocular vision don't miss it. The people who have had it miss it, particularly if they are involved in driving, if they are heavy readers, but in everyday activity they miss it. They want it and we try to provide it for them if we can.

Q With the monocular extraction of a cataract, that is an operation in one eye, would that present some difficulty to the individual who is used to binocular vision?

A Yes, particularly if he is not a candidate and cannot wear a contact lens, and if his vision is not as good in the other eye. The vision has to be decent in the other eye in order to have that binocularity.

Q Have contact lenses since 1972 -- has there been an improvement in them?

A There has been an improvement, but not enough of an improvement. This is the factor responsible for the new type of surgery currently available, the introduction of an artificial lens in the eye after the cataract has been removed. This eliminates the monocular factors which make it impossible to see with both eyes. But this is another step in trying to provide binocular vision for patients.

It is a poor one. Hopefully in the future contact lenses will be so good that we don't have to put a lens inside the eye. But today they are not good enough. Therefore, we have gone into this more dynamic field of putting a lens inside the eye, which does introduce again some other factors of risk to the patient.

Q When did this intraocular lens procedure develop --

A It's been around for a number of years. However, it has only become a factor in this country, an acceptable factor, in the past year or two.

Q Does that procedure have its complications?

A Yes.

J As part of that procedure, I assume once the

cataract is extracted, the lens is inserted?

A Absolutely.

Q At that --

A In the same sitting. It can't be done later. It cannot safely be done later, in my opinion.

Q Doctor, is binocular vision considered necessary or useful in house work?

A In my mind, it doesn't matter whether one is a house wife, an engineer, a surgeon or a lawyer. One who is used to depth perception and binocularity, wants it and needs it for driving, for reading, for everyday house work and for shopping. Any activity is enhanced and improved by the use of depth perception, binocularity.

Q You, I assume, are familiar with posterior subcapsular cataracts?

A Yes.

Q Doctor, a posterior subcapsular cataract is a peculiar type of cataract, is it not?

A Yes. It has particular optical and natural course tendencies that others do not and origin tendencies.

Q What is the typical phenomenon that you would expect to find in a patient with posterior subcapsular cataracts as far as everyday activities are concerned?

A The principal optical or vision deficit with

with posterior subcapsular cataracts lies in the patient's capability to see for reading and on bright days. These are easily understood, if the jury would consider that for in bright light the pupil gets smaller and when we tend to read the pupil gets smaller when we look at close images.

When this happens, less light goes through the center of the lens. This is where the posterior subcapsular cataract is and the light rays do not penetrate it. In a more diffuse haze, the other type of cataract we see, the nuclear cataract, it does not necessarily produce this phenomenon.

Q Doctor, there has been some testimony here that a posterior subcapsular cataract would not interfere with central vision or central acuity in reading.

A I don't know who said that, but I strongly disagree.

Q If a pin hole were inserted in a piece of cardboard or some other thing and you focused your eye through that pin hole, would you have better vision, that is better straight vision, on the other side of that hole?

A With a posterior subcapsular cataract?

Q Without a posterior subcapsular cataract.

A If your vision were not perfect to begin with, yes.

Q Assume a --

A It is like a pin hole lens on a camera. It gets rid of all the abberations and we get a sharp image.

Q Substitute behind that cardboard or behind that tiny aperature or hole a posterior subcapsular cataract. What sort of vision would you have in looking through that hole?

A No improvement. If it were a more nuclear cataract, we might have improvement.

Q With respect to posterior subcapsular cataracts, in an uncorrected eye with vision of 20-60, would that permit reading activity by use of that eye only?

A Not usually.

Q Would that enable a person to have enough vision to operate a motor vehicle?

A Not at all.

Q A posterior subcapsular cataract uncorrected with visual acuity of 20-60, with the lights out and with corrective lenses being brought down to 20-30, would that permit reading?

A Unless one wants to read in the dark, which is

not possible, or exist in the dark, that's functional vision that is sub-par for reading or driving, under normal circumstances.

Q Would that permit, Doctor, with correction, say, in the day light, with a corrective lens, would that permit reading?

A Not usually.

Q Would it permit driving?

A Not usually. It does it by state law -- you are saying 20-30? Not usually.

Q Brought down to 20-30, with a posterior subcapsular cataract?

A I doubt that the vision would be 20-30 under those circumstances.

Q In daylight?

A In daylight.

Q With any type of lens?

A With any type of lens. And the brighter the light, the worse the vision. Headlights at night and bright sun during the day.

Q Doctor, is there any degree of predictability as to when one cataract or another cataract will mature to the point of eliminating all or most useful vision?

A Not accurate way. However, a posterior sub-

capsular cataract tends to be more predictable in its maturation, particularly when it shows signs of activity.

THE COURT: In the expression posterior subcapsular cataract, what does the word subcapsular connote?

THE WITNESS: It means that the lens itself is enveloped beneath a capsule of tissue, and it is not the capsule itself that becomes opacified, but the tissue just beneath it or subcapsular.

THE COURT: What is there about a posterior subcapsular cataract that apparently makes it at the center of the lens?

THE WITNESS: A good point. May I use the board?

THE COURT: Yes.

MR. BEGOS: I have a model here that might help you.

THE WITNESS: If one could conceive of that model, the lens sits in the center of the eye, this is the cornea, and here is the lens, and the pupil is made by the opening in the iris. As rays of light come in, they tend to bend toward the posterior or back of the lens, and as they bend, they tend to go through that area and some of them pass through completely directly without bending, but most of the rays pass through that area.

As they do, they are interferred with by this

posterior opacification. So we may have essentially a lens that is not totally mature and in its immature state produces severe optical deficit.

On the other hand, we may have a diffuse haze through the lens and rays pass through that, through different spaces, very easily.

THE COURT: That's really not an answer to the question I had in mind. Is there anything about a posterior subcapsular cataract that causes it to localize in the center of the lens instead of being at some other place in the lens?

THE WITNESS: It doesn't always localize there, but it usually does and we don't know why.

THE COURT: How come this one was localized there?

THE WITNESS: I don't know.

THE COURT: You are assuming it was?

THE WITNESS: It usually is.

THE COURT: You don't know why?

THE WITNESS: I don't know why it usually develops there, but they usually do. They may develop elsewhere. If she was visually symptomatic, it probably was there.

THE COURT: What is there in the medical record that causes you to assume or conclude that her posterior

subcapsular cataract was at the center of the lens?

THE WITNESS: Reduced vision that was better in the dark, because her pupil enlarged and the rays passed through it.

THE COURT: All right.

THE WITNESS: It still is an assumption, though.

BY MR. BEGOS:

Q Would the inability to read newspapers prior to correction be another indication?

A Yes. Again the pupil gets small for reading and the lights do not pass through it. The patient in the record was not able to read, and that's another bit of evidence in support of that.

Q Doctor, I am going to give you some figures with respect to the patient's left eye on four office visits of Dr. Knapp and ask you the significance of them. With respect to the left eye, on June 19, 1970, uncorrected, 20-60 plus. On 11/18/1970, some five months later, 20-60. On September 15th of 1971, 20-80. On September 18, 1972, 20-400 uncorrected.

What is the significance of those four uncorrected visual acuity measurements?

A Provided that the rest of the eye was healthy, the cataract is active.

Q Is active?

A Yes.

Q With respect to the right eye, Doctor, at the same times; June 19, 1970, 20-25 minus, uncorrected. November 18, 1970, 20-25 minus, the same as the prior date. September 15, 1971, 20-25 minus, uncorrected. September 18, 1972, 20-60, plus 1, uncorrected.

A The same comment as for the other eye. It is asymetrically following the course and its activity of the more advanced eye on the left.

Q With respect to an active cataract as contra-distinguished to, say, an inactive cataract, is there any degree of predictability with respect to maturation?

A Again, it varies widely. But with evidence of change and activity, one can be more predictive and accurate in his predictions.

Q Doctor, is it a matter of professional judgment back in 1972 whether or not based upon that pattern of visual acuity in a patient, to contemplate or consider bilateral cataract extraction during the same admission?

A Yes.

Q Was that in conformity with practice in this community?

A Yes.

Q In October, 1972?

A Yes.

Q Doctor, with respect to consent, informed consent, was there a practice in the community in 1972 with respect to informing patients with respect to the contemplated surgery?

A Yes.

Q Doctor, I want you to assume that Dr. Knapp in this case advised Mrs. Johnson in the presence of her husband that there was a 90 per cent or better chance of success in a cataract extraction, and also advised that there was also a danger of losing vision and/or losing sight.

Would that information in your opinion satisfy the community standard with respect to informing a patient prior to this type of surgery?

A Yes.

P Doctor, I want to change that hypothetical question slightly and instead of inserting 90 per cent or better, I want to insert a 95 per cent success rate.

With that change or with that modification of the premise, would that change the community standard or change compliance with the community standard?

A No.

Q Doctor, I want to withdraw from the hypothetical any information to the patient of any loss of vision or blindness. The physician simply informs the patient that there is a 90 per cent or better chance of success of the cataract extraction. Would that comply with the standard?

A No -- I mean yes, it would comply with the standard.

Q I want you to assume that the physician, changing the factor again from 90 per cent to 95 per cent, informs the patient that there is a 95 per cent chance of success and tells them nothing else with respect to the procedure. Would that satisfy the standard?

A Tells them nothing else in respect to -- I am not sure I follow that.

MR. BEGOS: Withdraw the question.

Q A physician informs the patient that there is, instead of a 90 per cent or better chance of success, that there is a 95 per cent chance of success in the performance of a cataract procedure and offers to answer any questions that the patient may have with respect to the procedure. Would that satisfy the standards in the community in 1972 with respect to informed consent?

A Yes.

Q Doctor, was it the practice in this community

in 1972 with respect to informed consent to enumerate all of the risks of cataract extraction?

A No.

Q Was there any reason in 1972 to not so reveal?

A Well, there are a number of reasons. First, I don't think it is possible for anyone to understand all of the risks. Secondly, a list would be voluminous and entail numerous entities. Many obscure entities that very rarely are encountered, many that are poorly understood.

It would also serve negatively to instill certain fears on the part of the patient that are undesirable, not only in the operative and postoperative and preoperative state, panic on the part of some patients.

I don't think it is necessary, and I don't think it is commonly practiced here in the community. However, there are some individuals, selected individuals, who wish to know as much as possible, and these individuals should be offered as much explanation as conceivable, as much as they can understand and as much as they wish to know within the judgment of the doctor to the point where he is not going to totally panic the patient so that overall poor judgment will be used.

Q Doctor, how does one determine who to satisfy with information and in what manner to impart that

information to the patient?

A Again, this is the art of medicine. The doctor must make that decision in his explanation of the procedure to the patient, the potential benefits and risks to the particular individual. In his mind, how much does the patient know and how much will he understand and how much will benefit his understanding.

Provided certain fundamental concepts or guidelines are presented, such as the overall success rate and the contingency for some undesirable result.

Q In a nervous individual, what is the practice with respect to informing?

A Reassure the patient, calm the patient, and to not say or do anything that would totally disrupt her emotional status or his emotional status.

Q Doctor, what has your experience been with so-called active cataracts, and I want you to assume a cataract that has within one year reduced visual acuity from 20-25 minus to 20-60 plus, how long, if you have any opinion, would it take for that cataract to mature and interfere with further vision?

A I have no opinion in the individual case because of the wide variation, but it is likely that that patient soon, relatively soon, will encounter difficulties,

further difficulties. She already has difficulty.

Q Has it been your experience with a cataract that has manifested in that one year period that ability to decrease vision in that way for that cataract to remain stationary and not interfere --

A It can happen, but it is unlikely. I have seen such changes take place in a matter of weeks, and it is not uncommon for a few months later, for the vision to join the fellow eye with marked deterioration.

Q When you say it is unlikely, would you give us any percentages one way or another?

A I have no figures.

Q Doctor, you have reviewed the operative reports of the two cataract extractions performed by Dr. Knapp, have you not?

A Yes.

Q Did you find, Doctor, that those cataract extraction procedures were in accordance with accepted practice in the community?

A Yes.

Q Was there any indication of any difficulty or any unsuspected event in thecourse of the surgery?

A No.

Q If such an event occurred in the course of either

cataract extraction, should it be noted in the operative record?

A Yes.

Q Doctor, are you familiar with the fees that were charged for cataract extraction in this community in 1972?

A Yes.

Q What were those fees, Doctor?

A The fee for cataract surgery here in the city ranged between $750 and $1200 at our hospital.

Q Was that for each extraction?

A Each extraction.

Q Was there any difference for a bilateral extraction?

A No.

Q In other words, if there were two cataracts during the same hospitalization, it would be $1500 to $2400, is that correct?

A Yes.

Q Would you feel that a fee of $500 for each cataract extraction was beyond that which was reasonable in this community?

A It is a very fair and very reasonable level.

Q Would you have an impression of a physician who charged $500 for each extraction, that he was anxious to

do a second extraction to make $500?

MR. RHEINGOLD: I object to that question, your Honor.

THE COURT: Sustained.

Q Doctor, coming back to cystoid macular edema for a moment, you have indicated in your earlier testimony the etiology of it and the unfamiliar tear characteristics of it. Based upon your review of these records, what did this bilateral cystoid macular edema go on to produce with respect to Mrs. Johnson's eyes?

A Reduced central vision.

Q With respect to the right eye, a corneal problem developed?

A Yes.

Q In your opinion, based upon a reasonable degree of medical certainty, what was the competent producing cause of that corneal problem that required corneal transplant?

A Based on my review of the records, the changes in the cornea were compatible with the overall inflammation that was present in the eye, which certainly could have effect on the cornea and its integrity and on its facility to remain clear, leading ultimately to a penetrating keratoplasty.

THE COURT: Leading ultimately to what?

THE WITNES: Corneal graft, keratoplasty, transplant, graft of the cornea, they are all the same word.

Q Doctor, are you familiar with the defendant Phillip Knapp in this case?

A I don't know him personally, but I know him as a physician and an ophthalmologist.

Q What is his reputation -- are you familiar with his reputation as an ophthalmologist?

MR. RHEINGOLD: Objected to, your Honor.

THE COURT: You are asking him about Dr. Knapp?

MR. BEGOS: Yes.

THE COURT: Sustained.

Q Has Dr. Knapp, to your knowledge, lectured at your institution?

A Yes. Frequently.

Q Has he lectured at other institutions in the Metropolitan area?

A Frequently.

Q Has he lectured at institutions, medical schools, et cetera, throughout the country?

A Frequently.

Q Do you know whether he has lectured at institutions

and medical schools throughout the world?

A Frequently.

Q Are you familiar with Dr. Coleman?

A Yes.

Q Do you know whether Dr. Coleman has lectured --

MR. RHEINGOLD: I object to this, your Honor. You have dismissed Mr. Coleman as a defendant in this case.

THE COURT: It is irrelevant.

Q Doctor, based upon your review of all of the records in this case, particularly the records relating to Dr. Knapp's treatment of this patient during the period that he had her under his care, do you find any departures from good and accepted practice on the part of Dr. Knapp?

A No.

Q Doctor, in June of 1973 this lady left the care of Dr. Knapp and came under the care of another physician, as the records reveal. Is that correct?

A Yes.

Q Is it good practice on the part of the succeeding physician to obtain the records or information relating to prior treatment rendered to the patient?

A Usually, yes.

Q Would the records and information in your opinion,

based upon a reasonable degree of medical certainty, with respect to Mrs. Johnson's prior course, have benefitted the succeeding physician as to treatment and care of the patient?

A In general, yes.

MR. BEGOS: I have no further questions.

THE COURT: We will take our morning break now. Ten minutes.

(Recess.)

CROSS-EXAMINATION

BY MR. RHEINGOLD:

Q Doctor, one of the last questions you asked and answered was that in your review of these records, you found no departure on the part of Dr.Knapp from the standard of care that existed in 1972, is that correct?

A Yes.

Q When you were giving your opinion, you were basing it on those records that you enumerated that you had read?

A Yes.

Q You probably had some conversations with Dr. Knapp and Mr. Begos before you took the stand?

A Yes.

Q Didn't they tell you that we claim in your case that plaintiff said she did have useful vision out of her right eye?

A No.

Q No one has told you that?

A No.

Q Doctor, I'd like you to assume that the contention of Mrs. Johnson, who sits out back there in the corner with the white sweater on is that she did

have useful vision out of her right eye. I want you to assume that, Doctor.

A I read in the notes that she stated she couldn't read.

Q That's right, Doctor, and that's what Dr. Knapp told you, isn't that true?

A Yes.

Q And Mr. Begos told you that?

A Yes.

Q Now I want you to assume our side of the case, Doctor, because I assume as a professional person you can keep various sets of facts in mind, and I want you to assume that out of that right eye Mrs. Johnson had satisfactory vision to her. That would be a departure from the standard of care which existed in 1972, would it not, to perform a lens --

MR. BEGOS: Objection to the form.

Q To perform a lens extraction upon that eye?

MR. BEGOS: Objection to the form of the question.

THE COURT: I sustain that. I don't think she testified that she had "satisfactory vision" to her.

Q I will try and recapitulate as best I can the testimony that Mrs. Johnson gave from the stand, that out

of her left eye she could see virtually nothing. This was back in September and October, 1972. Out of her right eye she could see sufficiently to drive, to read a newspaper, to read magazines, to read her students' school reports, to read her mail and to do her housework.

Would it be a departure in your opinion, sir, fromthe standard of care which existed at thattime to perform the cataract extraction on that eye?

A I think it is false to assume anything. I think when a doctor listens to a history by a patient, he takes the information and then tries to take that subjective statement and determine objective evidence in support of it. The patient said she had no vision at all in her left eye. That's false. She had vision in her left eye. Poor vision.

Q I meant to say useful vision, Doctor.

MR. BEGOS: Can the doctor be permitted to continue answering?

THE COURT: I think he finished his answer.

Q I don't want to cut you off.

A She said she could read or couldn't read. The doctor's obligation is to see if that's true and make every attempt to rectify it.

Q Are you capable, Dr. Yannuzzi, of accepting

what I am telling you, that the woman never said she couldn't read a newspaper. You read that in Dr. Knapp's notes?

A Yes.

Q I want you to jorget that now. I want you to put that out ofyour mind and I want you to assume the woman said she could read newspapers. I am asking you whether or not it was a departure from the standard of care -- was it not a departure from the standard of care to do cataract surgery upon that eye?

A I suggest to you, sir, that her statement that she could or could not readis merely a statement-- this has to be confirmed or denied by the clinical examination, and Dr. Knapp's note confirms that she couldn't read under usual situations.

THE COURT: Is it your testimony, then, that it was the accepted standard of medical practice in New York in 1972 not to accept the patient's represetnation concerning her degree of --

THE WITNESS: Not totally.

THE COURT: Concerning her degree of visual acuity?

THE WITNESS: Not totally.

THE COURT: Concerning her degree of visual

acuity?

THE WITNESS: Not totally. If the patient said she couldn't function, make an attempt to make her functionable. If she said she could function, why, then, that must be confirmed in terms of her individual needs.

Q In the last analysis, it is the patient's decision to have an operation, is it not?

A Yes.

Q If the patient is satisfied with her vision, then a physician shouldn't perform an operation upon that eye, isn't that true?

A That's true.

Q That wouldn't make a difference when you saw a posterior subcapsular cataract or not, Dr. Yannuzzi?

A No.

Q It wouldn't make any difference whether the person had correctable vision of 20-35, 20-30, 20-40, isn't that true?

A The absolute acuity is independent of the individual needs. It is one factor in the decision.

Q In the last analysis, isn't it the individual needs, the lifestyle of the patient, the factor that determines when cataract surgery is performed?

A It's one of the chief criteria.

Q Isn't that more important than what you are able to do with your lenses in the office?

A No.

MR. BEGOS: Objection to the form of the question.

Q Which is more important, Doctor?

A The total evaluation, the summation of all of the findings, the patient's needs, the clinical findings, the knowledge about the pathogenic factors involved. All of these factors collectively enter into the decision to proceed with surgery.

Q Let's turn to the patient's subjective complaints to her visual acuity. Do you find any readings among Dr. Knapp's notes of what her vision was like in a regular lighted room like this, not a room with the lights down, with corrected lenses applied to her eye in September of 1972?

A The notes don't state specifically what the background illumination was.

Q Without regard to the background illumination, you read, did you not, that she had 20-30 minus vision?

A Dr. Knapp has told me that he customarily works in the dark, subdued lighting.

Q Have you supplemented your knowledge about Dr. Knapp's records from conversation with Dr. Knapp?

A Yes.

Q Did he tell you whether or not he measured this woman's vision in a room with lighting like this room?

A Yes. He said it was in the dark and -- he tested her both ways.

Q What did he tell you he found about her eye vision when he had the lights up, like in this room?

A It was dim, her vision was less when the lights were up.

Q What did he tell you it was?

A The vision when the lights were up was 20-60.

Q With corrective lenses?

A With corrective lenses.

Q Did he tell you he just didn't happen to record that in his notes?

A Notes are -- in themselves do not reveal all of the findings of a doctor. Notes are symbolic of the critical or vital findings one reports. Dr. Knapp would have as much trouble with my notes as I would with his or Dr. Sears' or anyone else's notes. We have

our own special way of doing it.

Q A special way of doing it might for example refer to codes or abbreviations you would use?

A Abbreviations, our methods of putting down vital information, implied information, associated manifestations, a variety of things.

Q Certainly, Doctor, you would aim personally to write down the important things on your chart, wouldn't you?

A The things that I think are important.

Q Right, to you. If three or four years later you knew you would have to say something about it, you would certainly like to have it written down, wouldn't you?

MR. BEGOS: I object to that, your Honor.

MR. RHEINGOLD: I withdraw it, your Honor, I am sorry.

Q Is determining a person's correctable vision where there is a cataract in their lens an important determination?

A Yes.

Q Would it not be an important thing to write down?

A Not to everyone. To the particular doctor,

his style of keeping notes, it depends. I had a resident once who wrote two pages of notes on every patient he saw, and we couldn't decipher one bit of critical information from that until he learned to be concise, recording only salient factors that were communicable to others.

Q I believe you said that a person's correctable vision in a room with the lights on is a salient factor.

A Yes.

Q You record that, don't you, Doctor?

A Not always.

Q Sometimes?

A Sometimes.

Q Let's turn, Doctor, beyond the patient's subjective complaint and beyond the visual acuity to what the doctor sees in the eye. I think you said that's important too?

A Yes.

Q In this case you have taken from Knapp's records and his discussion and taken his statement that there was a posterior subcapsular cataract?

A Yes.

Q Did I understand you to say on direct that

you didn't know from reading his notes where this posterior subcapsular cataract was?

A That's right.

Q Do you know how dense it was?

A No.

Q Presumably it was a good deal less dense in the right eye than the left eye?

A Yes.

Q Did you notife if Dr. Knapp was able to look into the right eye and see the fundus whereas with the left eye he could only see it dimly?

A Yes.

Q As his honor asked you, posterior subcapsular doesn't necessarily mean in the center of the rear of the lens, as you have drawn it, isn't that true?

A It usually does.

Q Did you see any drawings made by Dr. Knapp of where these cataracts were?

A No, I didn't.

Q As a matter of fact, many physicians do make a drawing, do they not, in their office records of where the cataract is?

A Many do.

Q That would be an assistance, for example,

to let us know in what way it is progressing?

A On the other hand, in doing the funoscopy and doing the slit lamp biomicroscopy and in taking the vision in a variety of ways, these findings are apparent.

Q Doctor, you are saying you know something about the type of posterior subcapsular cataract because of the way it affected the vision?

A Yes. I also said that it's an assumption of mine. I don't know definitely.

Q Did you see any photographs of these cataracts in Mrs. Johnson's --

A No, I didn't.

Q You can --

A If I saw photographs, I wouldn't have to assume. I would know.

Q There is a technique and there was in 1972 to hook up a camera to a slit lamp to take a picture, was there not?

A Yes, but not of this finding. We don't customarily or in this town I doubt that -- very few people would photograph a cataract.

Q At least you agree with me it was photographable?

A It is photographable, but I doubt that anyone

employs that practice. We certainly don't in our office, and we don't at the Manhattan Eye and Ear Hospital.

Q There was some laser treatment later on given to Mrs. JOhnson's eyes. Did you see any photographs from there?

A Yes.

MR. RHEINGOLD: Could I see them, Mr. Begos? I have never seen them.

Q Laser treatments, were there any photographs taken by Dr. Coleman that you have seen of laser treatments?

A No. I haven't seen any.

Q What Mr. Begos has handed me are photographs of the eye that were taken by Dr. Sears, is that the ones you have seen?

A Yes.

Q Those were the inside of the eye and the outside of the eye, and so on?

A I don't know if the outside are Dr. Sears'. Are those?

Q Just to settle thatpoint, Doctor, why don't you look at this sheet which we have taken out of Plaintiffs' Exhibit 9 for identification --

A Yes, these are the ones.

Q So you would agree, Doctor, that Dr. Sears did take various photographs of the inside and the outside of the eye?

A Yes.

Q And you have seen no photographs taken by Dr. Coleman or anybody else, or Dr. Knapp or anybody else at Columbia Presbyterian Hospital?

A Yes, these photographs were taken in September of 1973, three months after Dr. Sears first saw the patient.

Q To repeat my question because I don't believe I got an answer, you have seen no photographs taken of Mrs. Johnson's eyes while she was --

A No, I don't know if any are available.

Q Doctor, you said that at your institution bilateral surgery, both eyes being -- both lenses being removed at one hospitalization, is fairly common, in fact I believe you said 25 per cent?

A 25 per cent. I checked on it this morning.

Q In your own time you said it ranges 30 to 40 per cent?

A 30 to 40 per cent.

Q Did you check on that this morning too?

A Last night.

Q Are you a member of this team?

A Yes.

Q Do you ever operate on eyes that don't need to have cataract extractions?

A No.

MR. BEGOS: Objection to the form of the question.

THE COURT: Sustained. The jury will disregard it.

Q Are all of your 30 to 40 per cent of your patients where your team has done bilateral cataract extractions patients who needed bilateral extractions?

A Yes. The same question.

Q Excuse me?

A The same question.

Q You let me ask the questions, Doctor. I suppose there is a variety of personalities among ophthalmologists, Doctor, some are more aggressive and some are more conservative?

A I don't think the words aggressive and conservative apply in the decision making. I htink it applies to one's convictions as to what is in the best interests of his patients.

Q Did Dr. Knapp tell you that he testified yesterday that he had a conservative approach and that he had rarely done bilateral cataract extractions?

A Yes, he told me that he did. I don't know that he used the word conservative, but he told me that he rarely did it.

Q If a doctor had in the long years of his practice had done bilateral cataract extractions only four times and yet over all those years had done hundreds and hundreds of cataract extractions, would you call that a conservative record?

A Not conservative, but I would call that a statement that the particular doctor employed extreme thought in making the decision to go ahead with bilateral surgery in this particular individual.

Q So would you say that that had become Dr. Knapp's own standard of care as far as how he handled his patients?

A It certainly was his and compatible with everyone else's in this community.

Q Did you say compatible?

A Compatible.

Q Is doing it four times in his lifetime compatible with a team that does it 30 to 40 per cent?

THE COURT: What do you mean by compatible?

MR. RHEINGOLD: The doctor used the word.

THE COURT: I think it is unfortunate.

A It is not out of line with what other people do, and as I said earlier at our hospital itself, while the figure is 25 per cent overall, some elect to do it rarely, and others do it more frequently.

Q In your experience are there some doctors that do it as rarely as I have had you assume Dr. Knapp has done it over the years?

A Yes.

Q There is certainly, sir, some benefit to the patient, as you said, in doing both at one time?

A Yes.

Q And that is primarily, I take it, that it is to the convenience of the patient?

A Convenience to the patient and -- well, convenience to the patient, right.

Q Certainly nothing particularly in the realm of good for health of the patient to do it both at once, is it?

A The health?

Q I mean, it is primarily a cost and convenience?

A Nothing good, nothing gained.

Q On the other hand, Doctor, in deferring surgery, in doing let's say the worst side, the poorer of the two eyes, and waiting on the other eye, there is a positive benefit to the patient, is there not?

A More specifically --

Q For example, if something disastrous occurs in the first eye, then we can say thank goodness we didn't do the second eye?

A It depends upon whether the disaster is avoidable and preventable in the other eye.

Q Let's assume it is for the moment. Assuming it was, then it was of positive benefit to the patient in having deferred surgery in the other eye?

A I can't think of a single avoidable unexpected disaster that can be planned for in the other eye, including cystoid macular edema.

Q Let's come to cystoid macular edema for a minute. You say it has unknown cause?

A Unknown cause following cataract surgery.

Q Unpreventable?

A Unpreventable.

Q If you had had cystoid macular edema appear in one eye becasue only one eye needed surgery and five

years later you were doing the second eye, would you approach that eye with more caution, Doctor?

A People have tried this and haven't prevented its onset.

Q Did they try it because they had --

A Not more caution, but -- the word caution does not apply here. The word different technique, different acceptable technique, alternative technique, and this doesn't prevent it.

Q They used that different alternative acceptable technique in the belief or the hope that it might produce a different result?

A That's right. But no technique has been devised yet to do that.

Q Might be several years from now?

A It hasn't been since its description, and we have already had 15 to 20 years elapse, and I have devoted the past two years of my life on an alternate modality, which was extremely encouraging on a pathological and theoretical basis, but failed, a new modality for treatment, but it failed in the controlled study.

Q You haven't given up, Doctor?

A I am looking for other explanations. I am lost at the moment.

Q But you hope to find it?

A I am hopeful.

Q Just like intracapsular lenses, Doctor, you said that has byen a development in the last year or two?

A Excuse me?

Q You said that intracapsular lenses --

A No, intracameral.

Q Let's qive it a layman's term. Where you replace the lens that you take out with another lens within the eye itself, that's a relatively new technique?

A Relatively.

Q I think you said it wouldn't have been considered in 1972.

A It might by some, but not by the overall community.

Q But as we come down ot 1976, many more doctors would consider it?

A Many more doctors, includinq myself.

Q So that if Mrs. Johnson's right eye had come to a final point of maturity in 1976 when it had to be operated on, just assuminq that was true, then she would have the benefit of those four years of progress?

A Progress, in that we have a way to treat monocular aphakia with an implant, but reverse progress because that implant tends to produce cystoid macular edema more frequently. So it wouldn't apply to her and would threaten her eye even further.

Q You are saying, Doctor, that if a patient came to you and had this unfortunate consequence, the cystoid macular edema in the first eye, you certainly wouldn't have done the intracameral lens implant in the second eye?

A Absolutely.

Q But you would probably have tried, Doctor, would you not, to adopt a new technique that would avoid repeating exactly what was done in the first?

A I know of none.

Q There are various ways of removing a lens --

A But I know of no way of removing it to prevent this technique.

Q Nevertheless, wouldn't you try and use a way to avoid this disastrous result?

A I don't know of a way. I can't try an alternative way. I would have the same type of operation when it was needed that was carried out on her first side.

Q Exactly the same?

A That's right.

Q At your hospital, I forgot what that was, New York or Manhattan?

A Both. Not New York Eye & Ear.

Q Let's take Manhattan Eye & Ear Hospital. That's where you do most of your surgery?

A 100 per cent.

Q 100 per cent?

A All of my surgery.

Q Where there are cataracts in both eyes but the cataract in one eye barely interferes with vision, have you or any of your staff ever said to the patient, "Well, you may as well do both on one hospitalization and get it over with"?

A Not usually. It again depends on the individual's needs, the individual patient.

Q Do you have patients --

A And the pathology of the eye.

Q Do you ever have patients who need to get it over with for any reason?

A Need to get it over with?

Q Yes.

A No. We don't use that expression in our

decision, unless there are other findings in the eye than encourage us to make that decision.

Q Just that alone. May as well get it over with.

A No. It would play a role, but not a definitive one.

Q Not a decisive role?

A It would contribute, but not solely.

Q Doctor, would you say it is wrong to do unnecessary surgery.

A Absolutely.

Q And it adds to the general costs of not only the patient but of the whole medical care system?

A Oh, it is harmful.

Q And exposes the patient --

MR. BEGOS: Your Honor, I object to this line. There is no claimanywhere in this lawsuit with respect to unnecessary surgery.

MR. RHEINGOLD: I said in my opening, it is in my pleadings, I am going to say it in my summation. Unnecessary surgery.

THE COURT: Overruled.

Q Does unnecessary surgery, Doctor, add to the costs not only tot he patient but of the medical care

system?

THE COURT: That's self evident. Surgery costs money, therefore unnecessary surgery costs money.

Q Does unnecessary surgery exposes the patient to unnecessary risks of unforeseeable consequences?

MR. BEGOS: Objection.

THE COURT: It is self evident. Surgery exposes a patient to risk, whether it is necessary or unnecessary.

MR. RHEINGOLD: I will withdraw it.

Q You spoke about a person who was used to bilateral vision, is that correct?

A Yes.

Q Taking Mrs. Johnson, we know that in September, 1972 she had in her poorer eye, the left eye, 20-400 vision. Did you read that?

A Yes.

Q So she had no true bilateral vision as of that time, isn't that true?

A She had earlier, that's what I was referring to. That's why she was disturbed at the time she had 20-400. Otherwise the binocularity wouldn't have been missed.

Q Where is the evidence of her being disturbed,

Doctor?

A She has come to see a doctor complaining about her vision. She must be disturbed.

Q Doctor, when you are following patients who have insipient cataracts, you ask them to come back a year at a time?

A It varies. Depends on whether I see change or activity, whether the patient is responding to his visual deficit. I also instruct the patient to come back at a given time, but alternative at his will, come back whenver he feels that he needs to be seen.

Q If for example you had them on a yearly system and they show up exactly on the day appointed a year later, do you take it from their presence in your office that they are disturbed?

A I take it from the history at the time, that there is some complaint.

Q If the patient is in your waiting room, presumably the patient has come back because you asked the patient to come back?

A If they come back earlier, that would be an indication that he is more disturbed. If he came back when recommended, I would rely on the history taken at

that time.

Q The very appearance of the patient in the doctor's office is no indication, if he comes back pursuant to schedule, that his vision is disturbed or that he is disturbed?

A He kept his punctual visit, he didn't ignore an existing problem. He stated whether or not he is disturbed in the history, that's what I would go by.

Q Yes, Doctor. All I want to get from you, if you will agree with me, if it is true, that if the patient keeps an appointment, it is no evidence of the fact that the patient is in distress?

A Acute distress, true. I would agree with acute distress.

Q Turning to informed consent, Doctor, I understand your testimony was that the standard of care in 1972 would have been complied with by a doctor who referred to the percentage of success and then said "On the other hand, you could go blind," or a doctor who just referred to the percentage of success and didn't say it.

A That's true.

Q Do I understand you to say that both these standards of case existed then?

A I don't understand both of those. I am sure there are alternatives, and I am sure that there are no two people who use thesame approach, because there are no two individuals who are alike and no two patients who are alike.

Q Certainly there would be a standard below which if a doctor said less than a certain amount, you would be able to say from the stand that --

A I'd agree with you there.

Q What's too little to say as of 1972? What falls below that standard?

A To bring a patient into the hospital without his knowledge, without his consent, to performing a procedure that you haven't agreed upon.

Q If you go one step more and you say you need cataract surgery, I am going to put you in the hospital next month for cataract surgery, would that in your mind satisfy the existing standard at thattime?

A I don't think that is enough.

Q So if we just increment it --

A But I don't think there is a patient I ever encountered who would accept that.

Q None of your patients would?

A No.

Q Do you have from time to time patients who you find are rather reticent?

A Yes.

Q Patients who have a poverty of words that they can use to question you with?

A Yes.

Q And among that category of patients, you don't find any who don't ask questions?

A Even that patient wants to know what's happening to himself and why.

Q You would be satisfied, I take it, doctor, you yourself, Dr. Yannuzzi, back in 1972 -- doctor, how many years have you been admitted to practice --

A Excuse me?

MR. THEINGOLD: Withdrawn.

Q How many years have you been admitted to practice in the State of New York in 1972, by 1972?

A I think it was '66 or '65 that I started. Ten years -- by then it would be eight years.

Q Eight years?

A Yes.

Q You --

A Seven years.

THE COURT: Six or seven years?

THE WITNESS: Six or seven years.

Q You are saying that back in 1972 you would have been satisfied and the standard of care would have been satisfied to just say to that type of patient, that rather reticent type of patient, that, well, you know, there is a 90 to 95 per cent chance of success, and let it go at that?

A No. I would ask the patient to question me, and I'd volunteer some questions if he needed them, or if I thought it would be helpful to his understanding.

Q So you are saying part of the standard of care in addition is for the physician to say "No, do you have any questions?"

A Yes.

Q You say all your patients ask questions?

A Not all. Some do.

Q And some don't?

A And some don't.

Q And some don't presumably because they are a

little bit afraid to talk to the doctor, isn't that true?

MR. BEGOS: I object to that conclusion, your Honor.

THE COURT: Sustained.

Q Do you find --

A I mean, I should say some don't but ask basic questions, when, where, why, but don't go beyond that, what specifically. The basics. I don't think any patient is -- handles himself in that way nowadays. Even at our hospital with our service patients, patients ask questions. We answer questions. We volunteer information.

Q You say even with our service patients. Why should there be any difference --

A There is none. There is no difference.

Q Not worth mentioning?

A But you implied that there are certain patients who have a poverty of vocabulary. Spanish speaking individuals are asked questions -- ask for questions in their own language.

Q How do you kno handle those patients?

A We have social workers, we have doctors, including myself, who speak Spanish.

Q You have one sitting in with you if it is a language that you don't speak?

A We usually try to get a family member.

Q If the patient asks no questions, do you then volunteer something?

A Usually.

Q Is that part of the standard of care?

A Yes.

Q So that if a patient is told 90 to 95 per cent success rate and "Ask me any questions," and the patient sits there looking at you, then -- and asks no question, then your standard is to volunteer?

A Usually.

Q Does it make any difference in your practice or did it in 1972 that the cataract patient you were dealing with was a relatively young woman who had four children of a young age?

A No.

Q You wouldn't tell that person any more or anything less than a 70 year old man?

A Not particularly.

Q Do you feel that each of those people have the same equal need for vision?

A Yes.

Q They have the same risks that they can run?

A Yes. More or less, depending on the overall

health of the individual.

Q If a person is charged with an obligation, Doctor, of raising four children from a young age to the age of majority, would you not in 1972 have felt it necessary to give the patient more information about the adverse down-side consequences of doing cataract surgery?

A I would agree with you there.

MR. RHEINGOLD: That's all the questions I have.

THE COURT: Any redirect?

MR. BEGOS: Yes, your Honor.

XXX

REDIRECT EXAMINATION

BY MR. BEGOS:

Q Doctor, is it your opinion that the failure to volunteer further information after telling the patient the basic information that we were talking about and asking the patient if they had any questions, would the failure to volunteer further information constitute a departure from the area of informed consent?

A No, not at all. The other attorney asked me what I did particularly, and my particular response may be one approach, but the overall community may differ.

Q In your particular reaction or situation in dealing with a patient, would you take into consideration nervousness or condition of the patient?

A Yes.

Q Doctor, in considering when to do the second eye, assume it was not done during the first hospitalization. When based upon conditions of the left eye would you consider doing the second eye?

A In this particular patient?

Q Yes.

A I think the record indicates that on December -- which is approximately two months after her procedure, first procedure, her eye had developed an apparently perfect postoperative course. Her corrected vision was good, there was no evident inflammation, and at that time the second eye could have been considered for surgery, if it had not been done already, two months after the first. I think that was the end of December.

Q Doctor, based upon the uncorrected visual acuity in the right eye of 20-60 minus, and the fact that a posterior subcapsular cataract is described by Dr. Knapp, what would the central or reading type vision that the patient would have, what would you expect it to be?

A Less.

Q Doctor, would it vary, that central vision, that reading vision, would it vary with corrective lenses, bearing in mind a subcapsular cataract?

A Not substantially. Not at all. Again, it will depend on where that opacification was. If it was in the usual place, centrally, it would have even more of a marked effect on her near vision.

MR. BEGOS: Thank you.

MR. RHEINGOLD: No further questions, Doctor.

THE COURT: Thank you, Doctor.

(Witness excused.)

THE COURT: Dr. Knapp, if you will come back up here, you may cross examine.

P H I L L I P K N A P P, resumed.

CROSS EXAMINATION (Continued)

BY MR. RHEINGOLD:

Q Doctor, starting off, I am handing you a copy of the Columbia Presbyterian records, which is Plaintiff's Exhibit 1. I'd like you to look for your note of 11/1/72.

A Here it is.

Q You do make reference there, do you not, Doctor, to the possibility that in performing the second operation on the right eye of Mrs. Knapp the cryoprobe touched the back of the cornea?

A Do you mean Mrs. Johnson?

Q Yes. I am sorry.

A I merely say that we saw the touch above and we figured possibly the cryo had -- the cold had gotten to it.

MR. RHEINGOLD: Could that answer be read back?

(Record read.)

Q When you say you saw the touch above, what does that mean?

A That was the place that was thicker.

Q Do you refer to that in this note of 11/1/72

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as marked striate?

A The striate merely means that there was more folds and opacity in the cornea certainly than we had seen in the left eye.

Q Where do you refer to the touch above, as you used that term, other than the marked striate?

A I just put a question. I did not say it was due to that. You can see the question in the note.

Q That was a possibility that you considered?

A Yes.

Q As a matter of fact, Doctor, the cryoprobe does not actually have to touch the cornea to damage it, does it? It can come too close but not actually touch it?

A I don't know whether the transmission of cold through air is much less than it is through fluid medium.

Q When you say you don't know, do you mean you have not investigated it or you are not not that sure or what?

A I am not that much of a physicist, but it is my impression from college physics that cold does not damage through air as much as it does by actual contact or with wetting.

Q When we saw that movie yesterday, Dr. Knapp,

there was a time when that cornea was flapped over and drawn out toward the observer, isn't that true?

A Yes.

Q Then that white cryoprobe was coming down almost straight above?

A Yes.

Q That would be the point when it would be desirable to avoid touching the cryoprobe to the back of the cornea?

A Absolutely.

Q It appeared to me, Doctor, in watching that movie, that there was a very small space in which you have to operate.

A That's correct. The whole area is small.

Q I assume that extreme caution must be utilized to keep that probe away from the back of the cornea.

A Yes.

Q In any case, whatever the cause, something did develop in the back of the cornea?

MR. BEGOS: Of the right eye?

Q Of the right eye.

A I merely know that there was more striate than I expected.

Q As time went along, more and more things started

developing in the cornea of the upper right eye, isn't that true?

A No. The cornea of the right eye cleared up.

Q I am talking in her whole course while she was a patient of yours, Doctor. First you noticed striate, then you began to notice other things in the cornea of her right eye, isn't that true?

A The hospital record does not give me the whole course of the following --

Q I am sorry. Do you have in front of you your office notes?

A I don't have it with me. No. The course, as I recall it, was the striate lasted about two weeks in the right eye and on the next visit it was markedly cleared, and then actually the vision had come up to practically normal.

Q And then there came a point, sir, when there was a thickening noted in the cornea?

A There was always that little thickening above.

Q That was always there?

A I would think so.

Q Starting from the time of the surgery?

A Yes.

Q And there came a time when you noticed some

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sort of line in the cornea referred to as a line above?

A That's when it was clear below and then you could see the little wavy line across as shown in Dr. Coleman's drawing.

Q That remained there from the beginning to the end of your treatment of her, didn't it?

A Yes.

Q And as time went along, you began to see some changes in the cornea on the outer end, isn't that true? Some bedewing, epithelial bedewing?

A That followed the inflammation of the eye. I'd like to have the record, if I could. It would make it easier.

(Pause.)

MR. RHEINGOLD: I would like to see that whole folder, your Honor. The folder you had with you yesterday, Dr. Knapp, also in addition to your office notes, had various handwritten notes by you, did it not?

A Yes.

Q And some typewritten statements too? Whatever that folder is, your Honor, before I complete my cross examination, I'd like to have an opportunity to see the other records that the witness brought to the stand with him. At this point, Dr. Knapp, I am handing you your

records of your own office notes which were marked in evidence as Plaintiff's Exhibit 2. I think we were talking about this epithelial bedewing, and you say that came on relatively late in the course of your treatment of Mrs. Johnson?

A The first note about bedewing actually occurred while Dr. Coleman -- between the two times, the first two times that he saw her.

Q That was in February and March of 1973?

A Yes.

Q And then when you came back you observed it for yourself?

A Oh, yes.

Q The bedewing, I take it, is an accumulation of fluid?

A Little droplets. In other words, the droplets start out small and then they coalesce and they form like a cyst in the macula, except in the cornea you call them a bulla, like a hive.

Q At any time she was your patient did you observe actual bullae?

A No.

Q In your experience did you have what you call epithelial bedewing go on to coalesce into such a large

body of fluid so that they are bullae?

A It can go either way. Frequently bedewing above goes away because that's the air that has been traumatized most by the surgery.

Q It didn't go away during the time that you were there?

A It didn't come on until four months later.

Q So you are saying --

A I think that was probably a different type.

Q It takes a while for the fluid balance to change in the lens, does it not? The fluid in the front of the eye is only a reflection of damage to the back of the eye, is it not?

A You keep calling the lens and the eye --

Q I am sorry, I just misspoke. I apologize. Cornea.

A The front surface of the cornea could be the first part to show it, but it is true that it is an indication that your endothelial nunil on the back isn't working.

Q So that if the back of the nunil were damaged, then sometime later the front of the eye would show the damage?

A Not necessarily.

Q Again I said "eye" and I meant to say cornea. You say not necessarily?

A Yes.

Q Doctor, if you have your notes in front of you, when you were testifying on direct yesterday on the date of --

A I don't have those with me here.

Q Would you look at your own office note for November 14, 1972.

A Back to November 14th. Yes.

Q You made some explanation about the patient not using maxitrol as apparently you had intended?

A Yes.

Q Had you given the patient some written directions?

A Yes.

Q And those directions did not state to use maxitrol?

A Things are clipped together and one is a prescription that says maxitrol, one drop in each eye, so and so number times a day.

Q She didn't follow it or she didn't understand it or what?

A I can't explain how it happened. It is the

first time it ever happened to me.

Q Did you have yesterday that sheet of paper or some sheet of paper that tells you about the instructions you gave her?

A Yes.

Q Was that part of your folder?

A No, but I know --

Q In the folder you had in front of you yesterday, did you have a sheet about that?

A Yes.

MR. RHEINGOLD: It is here, your Honor, I should have seen it.

THE WITNESS: They were part of the discussion. I knew I put it back on that desk.

Q I apologize, Doctor. You are right. On top of your folder which is marked Plaintiff's Exhibit 2 for identification there were these Yale records.

A I understand. That was because you were questioning me. They said put them all together.

Q Could you show me, Doctor, the sheet that gives you the information about where there was a misunderstanding between Mrs. Johnson and your office?

A It turns out only using hyoscine, is what I wrote down.

Q That's in your own office record, isn't it?

A Yes.

Q Do you have a copy of the sheet of instructions you had given Mrs. Johnson?

A Here it is.

Q This is a sheet that's on your letterhead, Doctor?

A Yes.

Q The form which you have, Doctor, has got a statement "Use medication as noted below."

A Yes.

Q And on the written sheet, on this sheet that was given to Mrs. Johnson, did it state which medication she was to use?

A It had a prescription attached and it also had one statement, because I gave her the bottle she had been using in the hospital to use, and I wrote that out because she didn't have a prescription for that one.

Q On the particular sheet, which I am not going to mark as an exhibit, it did not state on the sheet it's "Use maxitrol."

A No.

Q Mrs. Johnson apparently became confused about that?

MR. BEGOS: Objection to the conclusion.

THE COURT: Sustained.

A The exact facts as I recall it is her husband was the one who said don't use it, and she said "I told you we should have used it."

Q You recollect that conversation?

A Yes, I do.

MR. RHEINGOLD: I'd like to mark as an exhibit, your Honor -- can I mark a Plaintiff's Exhibit at this time?

THE COURT: The whole file?

MR. RHEINGOLD: No. I may mark other parts of it, but I'd like to mark that sheet which Dr. Knapp has as Plaintiff's Exhibit 10, if I might.

MR. BEGOS: I have no objection.

MAX (Plaintiff's Exhibit 10 was received in evidence.)

THE COURT: As I understand what you are saying, Doctor, at the time that sheet, Plaintiff's Exhibit 10, was given to Mrs. Johnson, it had attached to it a prescription for maxitrol?

THE WITNESS: Yes, sir. Just for convenience, we put a paper clip with the various things. Sometimes they go home with three or four medications.

Q Dr. Knapp, will you look down in your office record for postoperative visits down to December 19, 1972.

A Yes.

Q Down there you have peculiar trouble seeing.

A Yes.

Q Were you able to arrive at any reason for that complaint?

A No. The examination was extremely difficult, and I tried twice to refract her and was unable to because when she closed her eyes the eyes went up and you can't refract when the eyes are under the lid.

Q Did you have a discussion with Mr. or Mrs. Johnson that day about the possible significance of this complaint she had?

A No, but I told her to continue the drops and come back in a week and we would try again.

Q According to your records, two days later you received a phone call.

A Yes.

Q Was that to you or to someone in your office?

A To me.

Q It says here "Husband phoned? Cause of Tuesday exam."

A Yes.

Q RX is prescription?

A No. That means the answer, really.

Q "Don't know but try again?"

A That's right.

Q What do you recall beyond this note of what Mr. Johnson said to you over the phone?

A He was present at every time I saw Mrs. Johnson, and he naturally was upset, because before she read so well and here she wasn't reading at all. I honestly thought that she was just a little extra nervous that day. But I couldn't be sure, so I wrote down that I didn't know why, but what we always do in a case like that is see them -- if you notice, that is very close to Christmas, and -- the 21st, so we saw her the day after Christmas.

Q She had these complaints on the 19th, is that correct?

A But she said peculiar trouble seeing.

Q Right. Then the 21st you said her husband called you?

A That's correct.

Q I asked you if you had any recollection of what he said to you on the 21st in addition to what you

have written down here.

A All he said he was alarmed, afraid, or whatever word you like.

Q What didyou say to him?

A I told him I didn't know why she had not been able to see, that I had seen nothing wrong, because then we went over and examined the eyes, and therefore I said we don't know the answer but we will reexamine her.

Q Doctor, do you feel that the condition that she had, that you couldn't get at the cause of then, in retrospect, at least, was the onset of this cystoid macular edema?

A No, for the simple reason that when she came back in on the 26th she saw 20-30 with her right eye and 20-25 with her left.

Q Then you are saying that it wasn't until her visit on January 9, 1973 --

A That's the first time I saw the edema of the macula.

Q When you write down here mild edema of macula, that's the same, I think you said, as cystoid macular edema?

A Yes.

Q That's the same as the term you used, Irvine-

Gass syndrome?

A That's the technical or the jargon of the description of the whole syndrome. The microcystic edema of the macula, some people call it. Others call it cystoid. That is the most prominent feature of Irvine-Gass syndrome.

Q Doctor, I took you to say on direct yesterday that cystoid macular edema is a fairly common condition observed post-cataract extraction?

A Well, when you get figures like Dr. Yannuzzi he is a research man who is very interested in this problem, and there are several other places in the country that are doing this, namely Miami, Los Angeles, that I know of. Maybe there are a lot of other places that are. But they are in every cataract injecting fluorescein, even though everything seems to be normal, and I happen to know that they sometimes see a mild edema of the macula even with 20-20 visual acuity. But this is not clinical.

In other words, most of us expect macular edema to reduce vision before we become at all alarmed.

Q What was your own testimony, Doctor, about whether it was common or uncommon or how many times you had seen it in practice?

A This was the first private patient I had ever

had with it, at least that I had recognized. In hindsight I think I could say that I remember one lady that two years following cataract developed edema of the macula, and I had no explanation. I had everybody working her up, and everything, and the reason I in hindsight think it was cystoid was that it cleared, which very pleasantly surprised me.

Q That was an event which had occurred in your practice before Mrs. Johnson?

A Oh, many years before. That was before Dr. Gass had come out with this fluorescein test so you could document what was going on.

Q You had only seen it once in your practice, and yet as you say Dr. Yannuzzi says he sees it I think he said 40 to 70 per cent of the time?

A Well, I told you that he was a researcher doing fluorescein in every patient. He isn't seeing it in his practice.

In other words, he is looking to try and evolve what happens in these cases, and he does a routine fluorescein test on every patient a few days after cataract extraction. I don't know exactly what his level is, I mean whether it is five days, seven days, twelve days. This is the highest figure that's recorded, to my

knowledge. The original Irvine article said it occurred in between 2 and 10 per cent.

Q In your experience, Doctor, two cases up to 1972 would have made a good deal less than --

A Wait a minute. I have seen some in the college.

(Continued on next page.)

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Q Coming to another area, Dr. Knapp, I believe you testified that the last time you saw the patient in June, 1973, she had no pressure in her eye, unusual pressure?

A It was at the upper limit of normal.

Q Did she or did she not have a pressure problem at that time while she was still your patient?

A I was a little worried that it might be starting, and so I placed her on Epinol, which is an Epinephrine derivative that tends to reduce the secretion into the eye. I also was leery because that was the eye that was receiving local steroids which also, in a susceptible individual, cause a elevation of pressure.

Q So you did have a concern about possible elevated --

A I had always had a concern, which is why I took it every visit.

Q There did come a time when you felt medication should be given while she was still your patient?

A Yes.

Q You said the patient did not keep her July appointment, is that correct?

A Yes.

Q As a matter of fact, after this June visit, June 14th, you received a letter, did you not, from Mr. Johnson

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telling you that she would not be coming to you?

A I don't think so. I was disappointed in not seeing her.

Q Have you looked through the entire file that you have in front of you there, Doctor?

A I will. As I recall, the thing was that there was a phone call to my secretary stating that due to the heat they were going to stay up in New Hampshire.

Q When did you get that in relationship to --

A I haven't found the note on it yet.

MR. RHEINGOLD: Your Honor, I am going to be reading through that whole file. Perhaps we can defer this question and I can find it.

THE COURT: All right. He will look for it during the lunch break.

Q Dr. Knapp, there is no question in your mind, is there, that when Mrs. Johnson came to you in September, 1972, that the only pathology or abnormality she had was the cataracts in her eyes?

A Yes. The only thing I found wrong with her eyes was the cataracts.

Q Other than that, as far as you examined her, her eyes were completely normal?

A Yes.

Q Other than that, her body, at least from whatever type of exam you did, was completely normal?

A I limit myself to examination of the eyes.

Q When she was admitted to Presbyterian Hospital under your direction a month later, was a physical done of her body?

A Yes.

Q Did you review that before you did the cataract surgery?

A Yes.

Q And there was no abnormality in her body?

A To the best of my knowledge there was nothing. Her body pressure was 150 over 90, which indicates -- the top number meaning the systolic, she was probably nervous, tnat is why it went up. Temperature, respiration, pulse were normal. Nose and throat, respiratory, cardiovascular, all that was normal. The impression by Dr. Pico, who was the resident, the same resident who helped me with the first operation, was that her condition was satisfactory.

Q Even during the course of the cataract surgery when you got a closer look at her eye, you saw no abnormality in her eye otherthan the cataracts, isn't that correct?

A During surgery is no time to look for

abnormalities.

Q But you didn't happen to see any?

A No.

Q Up to the end of the two cataract surgeries, there was no evidence to you of any intraocular diseases, other than the fact that this condition she had in her lens?

A Yes.

Q Doctor, today, as you know from her testimony and from what you have heard, Mrs. Johnson cannot see at all out of one eye and has very limited vision in her other eye. You understand that?

A Yes, I do.

Q Would you agree with me that her condition is a result of postoperative complications in the two cataract extractions?

A No, I wouldn't agree with you.

Q What part of her condition do you say is unrelated to postoperative complications?

A Well, if you mean by something that occurred in the postoperative period, I would agree with you, but I think the fact that she saw so well two months after the surgery indicates that this was not related to the operation.

Q What was it related to?

A Well, certain people -- I admit that following surgery you can develop this unknown caused inflammation. I was interested to hear Dr. Yannuzzi say that this can occur in non-operated eyes. I had always assumed that it was due to purely an operative -- postoperative. If you want to call this associated with a late postoperative condition, yes.

Q Another way of putting it, Doctor, would be that to a reasonable degree of scientific certainty, if there had been no cataract extractions, she would not have developed the conditions which she did develop after the operation?

A I think that's reasonable.

Q I think you agreed yesterday that she would not have developed cystoid macular edema or Irvine-Gass syndrome had she not had these surgeries?

A I believe that's correct.

Q Yet it is your testimony, Dr. Knapp, that everything you did in the treatment of this woman was within the standard of care which existed back in 1972?

A Yes.

Q What in your opinion was the cause for the adhesions or synechia which developed in her eyes?

A That was the inflammation that she developed in

either the end of February after I had left or in March. That had not been present before.

Q Did that have anything to do with Dr. Coleman's treatment of her?

A Dr. Coleman did not treat the eye.

MR. BEGOS: I object. That is no longer part of this case.

THE COURT: It might tend to exclude the relationship back to the original operation. Overruled.

A (Continuing) Dr. Coleman, if you can discount looking in with a bright light, because the first time he saw her he could see both maculae very well and drew a picture of them. That was the last day I saw her before I went off to the meetings. Then in the five days between February 22nd and February 27, 1973, the right eye had clouded up so much that he couldn't see well enough -- let's put it this way, you could see but you canrt shoot a beam into a hazy medium because it no longer focuses correctly. So we only treated the left eye. He can answer better than I. I wasn't there that day.

Q Will he be taking the stand?

A Yes.

Q When you came back you saw this haze and inflammation?

A Yes.

Q What was the origin or cause of the haze and inflammation?

A To the best of our knowledge, we weren't positive at the time because it certainly was a surprise to me, but part of the Irvine-Gass -- in fact the Irvine-Gass so-called syndrome, the whole pattern, as it is now recognized, is an inflammation, a pan inflammation of the entire eye.

In other words, it affects the retina, the uvea tract, that's the iris ancilliary body, and this explains the vitreous haze. The haze really at that point was what was cutting down the vision. The haze and the edema of the macula.

Q Dr. Knapp, you had the benefit, have you not, of looking over the subsequent course of Mrs. Johnson's eyes through the records of Dr. Sears and the hospital charts from the Yale-New Haven Hospital?

A Yes.

Q Were there in those records any clue to you of the cause of the conditions which have put Mrs. Johnson's eyes in the condition in which they are today?

A Dr. Sears stated on the first examination -- I think there is a copy of that in here somewhere -- no,

this is only the Yale-New Haven record. On his first examination -- have you got --

Q I have the whole record of Dr. Sears, all his office notes, which were marked for identification.

A Can we see the first examination? That would be one of the usual ones.

Q I am handing you another section that was pulled out specifically and marked B for identification, starting with page 1-114.

A That was in November. I'd rather have the June visit.

Q Can you find it in there, Doctor?

MR. BEGOS: It's on the bottom. Marked 1-130 and 1-131 and 1-129.

A Here is 1-130. When Dr. Sears saw her, the past medical history was negative. They even said she had never had any operations.

Q Was that an error?

A She had obviously had two cataracts.

Q I ask you, Dr. Knapp, was there in all your review of all the subsequent records, whether it was the first or last, whether you found any cause for Mrs. Johnson's present eye condition, other than what you have already testified to?

A I think it is the inflammation, and that's what caused the adhesions between the -- I even have a slide to show you how adhesions go back, and these were posterior. He noticed one posterior adhesion at that time. There was no mention of any of these anterior adhesions which could follow. If the iris is inflammed, it is swollen, and the rest of the uveal tract -- that's why the vitreous was so cloudy, and I think this progressed and obviously her pressure had gone up in the two weeks since I had seen her, and the two things that really are bad for a cornea are pressure and inflammation.

Q Dr. Knapp, you were discussing the right eye, were you not?

A Yes.

Q That's the eye that needed these two or had these two corneal transplants?

A Yes.

Q That's the eye that when you started on your treatment of her had correctible vision with lights down and in a dark room of 20-30 minus, is that correct?

A That's correct.

Q And in the left eye which had 20-400 vision, she has limited vision today after the cataract surgery, is that correct?

A It was 20-30 the last time I had seen her.

Q What is the cause of her limited vision in her left eye?

A Part of the Irvine-Gass syndrome is that it is a binocular phenomenon, usually, and I did not see her develop this, but if you had to retrospect it, I would guess that she got some inflammation there and perhaps some elevated pressure, and that that went ahead and the cornea in that eye -- she has two reasons, really, why her vision is down. One is that the macular lesion or the cystoid microcystic edema, whatever you want to call it, in the back of the eye obviously progressed and involved the pigment epithelium, so she now has similar to a macular degeneration in that eye.

You can't really tell how bad her vision is because the soft lens that she is wearing is not a visible lens, it is sort of a medical protection to keep the cornea from irritating her.

Q Are these conditions which you described secondary to or part of this cystoid macular edema?

A I would think so, yes. Not directly to the cystoid macular edema, but to the whole pattern of Irvine-Gass. It is the inflammation rather than the isolated finding, because it is a pan -- it affects all

the tissues of the eye.

Q That Irvine-Gass syndrome, whatever it is called, is, as you say, a postoperative complication?

A Yes.

Q But you say unpreventable?

A Everyone says.

MR. RHEINGOLD: Your Honor, that's all the questions I plan now. I would like to see this folder.

THE COURT: We will take our noon break now and come back at 2:00.

(Luncheon recess.)

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AFTERNOON SESSION

pm 2:05 p.m.

(In open court; jury present.)

MR. RHEINGOLD: Your Honor, I have several more questions of Dr. Knapp.

P H I L L I P K N A P P, resumed.

CROSS EXAMINATION (Continued)

BY MR. RHEINGOLD:

Q I am giving you your whole file back again, Dr. Knapp.

On the first sheet in there that I had premarked by the clerk as Plaintiffs' Exhibit 11, there is a report. Do you have the large sheet there, one typed by your office, I believe?

A Yes.

MR. BEGOS: May I see this, your Honor.

MR. RHEINGOLD: I will show Mr. Begos both 11 and 12, as I premarked them. I will offer 11 and 12 at this time.

MR. BEGOS: I have no objection. I would agree to the admission of the entire record, those portions of the record that are relevant, the doctor's office visits. These are just two letters or two separate parts.

THE COURT: Are you offering the entire record or just those two?

MR. RHEINGOLD: I will offer the whole folder the doctor has.

MR. BEGOS: Just those portions that are relevant. There are some post litigation things in there, correspondence, which is not relevant, and I would object to that.

THE COURT: They can be removed.

MR.RHEINGOLD: Your Honor, that folder was marked Plaintiffs' Exhibit 2-A. Previously other parts have been marked as other exhibits.

THE COURT: When you say the folder, you just mean the jacket?

MR. RHEINGOLD: The jacket. I will offer the jacket and all its contents as described by Mr. Begos as Plaintiffs' Exhibit 2-A.

(Plaintiffs' Exhibit 2-A was received in evidence.)

MR. RHEINGOLD: So the record is clear, I withdraw the offer of Plaintiffs' Exhibit 11 and 12 as separate exhibits.

Q Looking at the sheet in your record, Dr. Knapp, that happens to be marked Exhibit 11 for identification,

is there a statement at the bottom there relating to Mrs. Johnson's last appointment?

A It says 7/11/73, appointment cancelled by mail.

Q Does that refresh your recollection, Dr. Knapp, that your office did receive in writing a notification that Mrs. Johnson was not going to keep her July appointment?

A No, sir. I don't recall that. That would have been handled by my secretary. As I recall, she said it was a phone call from Mr. Johnson.

Q The sheet you have in front of you indicates it was by mail, is that correct?

A Yes.

Q I have also pulled out a letter from your file, Dr. Knapp, a letter you apparently wrote Dr. Garrity.

A Yes.

Q That was back in 1970, is that correct?

A Yes.

Q Was that a report back to Dr. Garrity after you had seen Mrs. Johnson for the first time?

A Yes.

Q Would you read us the contents of your letter?

A "Dear Dr. Garrity:

"On June 19th I examined your patient Mrs. Anna

Johnson. She does have early cataracts that are only unusual in their appearing in a person of her age. There is no way of judging their rate of progression, so I asked her to come back in the fall. Thank you for referring her. Kind regards, " et cetera.

Q Is that an accurate statement, Dr. Knapp, that there is no way of judging the progression of her cataracts?

A Yes.

THE COURT: Not after one examination?

THE WITNESS: That's what I am trying to say.

Q At that time?

A Right.

Q Did you also say in that letter to Dr. Garrity, that there was nothing unusual in her cataracts other than their appearing in a person of a relatively young age?

A Yes.

Q The last question, Dr. Knapp, and I will be through.

Can we go back to your office records which were previously marked Plaintiffs' Exhibit 2, and I think you have it in front of you in your folder there, on the left side of most of these records there are visual readings and comments. On the right side of your records there are

entries made. For example, the one you read before in 1972, "Much worse, unable to read newspapers."

A Yes.

Q Is it inevitable that what you put on the right side of this sheet is the patient's comments?

A Yes.

Q Is that the purpose of this?

A Yes.

Q There are occasions as you look through here where it is not what the patient said to you but what you understood to be the patient's condition, isn't that true?

A I would say the only one that you could do that. "Awakens with " -- on November 13, she came in stating that she awakened with bad frontal headaches and turns out only using the Hyoscine. This means I asked her questions what was she doing, and found out she was only using one instead of two drugs, two different kinds of drugs.

Q She didn't say to you, Dr. Knapp, "I have frontal headaches," did she? That s your translation of what it was she said to you?

A She said she had on her forehead, probably.

Q She didn't use the word frontal?

A No.

Q That's an example of where you listened to what

she was saying but you wrote down not her exact words, you translated it --

A I write down the gist of what the patient says.

Q Not verbatim, correct?

A Correct.

Q Now, would you look over to your note for example of January 16, 1973 and over on the right you have "Has a cold so OD cloudy." Certainly she didn't walk in and say that?

A Yes, she did.

Q She said "My OD is cloudy"?

A Right eye. I am not going to write out right eye. We either use OE, in New Haven, or ocular dexter in New York.

Q It is your recollection she came in and said her right eye was cloudy because of cold?

A Yes.

MR. RHEINGOLD: That is all.

REDIRECT EXAMINATION

BY MR. BEGOS:

Q Doctor, in 1970 you couldn't judge the rate of progression but in 1972, in particular in September 1972, did you have any idea or opinion or feeling with respect to the

rate of progression of the cataract in the good eye?

A The vision had changed from 20-25 to 20-60, which indicates that the -- Dr. Yannuzzi uses the word active, I usually say progressive. Could I explain one thing?

Q Yes.

A A cataract is not a growth. A lot of people think it is a growing organism. It is not. It is as though someone were throwing mud, in this type of case it is at your window. If there are chinks in the mud you can see them, if there aren't chinks, you can't see them in certain types. But it is not a growth like a tumor, or anything like that. It is an opacification of a clear lens.

Q How does that opacification extend or interfere with vision? Is that by spreading of the opacification, or what is it by?

A I think it is both by spreading and by new fibers or new areas becoming cloudy.

Q Dr., with respect a posterior subcapular cataract, does that have any penchant for a particular area of the lens?

A The fibers originate -- say the lens is roughly an eliptical circle, you know, it isn't a perfect circle, the fibers originate in the so-called equatorial areas, which

is the part around here, and then they go around each way and tend to meet towards the posterior pole.

Q By the posterior pole --

A That's the central area in the back of the cornea beneath the capsule.

Q Does the opacification --

A The ends of these fibers tend to become opaque first.

Q The ends toward the side or --

A Towards the center where they end. They start at the side and grow.

Q Which ends have a tendency to opacify first?

A The ones in the center of the visual axis, in the posterior central area.

Q Doctor, based upon what you saw with respect to the good eye in September, 1972, would you have any clear estimation of when that cataract would mature to such a point that it would, say substantially interfere with vision, such as the cataract in the left eye was doing?

A Well, in the one in the left eye, in the dark, in 1971, it had gone from 20-8 to 20-40 on that examination. In other words, I didn't write "Lights down" on that one, but it is the same principle as up above -- I mean as down below a year later.

So here is an eye that was 20-40 that went to 20-400, whereas the other went from 20-25 minus to 20-60. It still being partial, when the pupil dilated, you could see around the central opacity, and that's why I could see the back of the fundus so easily after dilation, and she could see better in the dark than in the light. You would assume then, that both cataracts were progressing. The reason we hadn't operated in the previous 2-1/4 years was because she could see well with each eye. Then the left eye became poor in 1971, and if both eyes had been the level of the left eye in 1971, we would have been willing to operate. But at that point the right eye was still a good 20-25. Then it gets down to 20-60, indicating it is progressing also, not nearly to the degree -- it is like everything -- finally all the chinks fitted together. In the left one you could hardly -- I had trouble seeing through it with a dilated pupil, whereas it was still easy to see around in the right one.

But the decision to operate at all comes when the better eye begins to be handicapped, and then you usually start by doing the poorer eye.

But in her circumstances we went through yesterday, due to the fact she had young children at home, we agreed to do both.

So the decision to do both was made before we did either. The only reason we would have changed that decision is if something untoward had happened in the left eye.

Q Doctor, do you have any estimate, any ball park figure, anything, with respect to when, if that right eye were unoperated upon in October of '72, it would reach the stage of the left eye?

THE COURT: You mean 20-400?

Q 20-400, plus or minus.

A If you judge by the progression of the other eye, which isn't a very accurate method, but if you want a ball park estimate, I'd say another year, that eye would have been around 20-400.

Q Then if that eye were not operated upon within that year, for whatever reason, there would be no vision, no useful vision?

A 20-400 is not no vision. It would be very limited vision, but she would certainly see light and dark shadows, and if the lighting were right she could even distinguish an E twice as big as Mr. Rheingold's E there. That's what the 20-400 is.

Q With cataracts, within a year progressing to

20-400, would they progress further? Can cataracts progress to such a point --

A They can progress to the point where all you see is light. No, you never see worse than light. A cataract is just like -- I don't know how much mud you show on the windiw, if you shine a light through it, you will see the light.

Q But you would have no useful vision, that is from the point of view of distinquishing objects or reading --

A No, your visual acuity for reading would have gone way before that.

Q As far as 20-400 vision where you could see the larger E, is that considered useful vision?

A It is considered economic blindness.

Q Legal blindness, doctor --

A I mean, as far as -- I think it is 20-200 or worse. Then you get an extra exemption from your income tax. We get that from patients who have that. Every year we have to fill a form out or we do fill a form out.

Q Doctor, with respect to a question that has been raised here with respect to the exact location of the opacity in the right and left eye of Mrs. Johnson, we know that it was a posterior subcapsular cataract. Do you have any recollection or based upon using that description,

can you tell where with respect to the geography was the exact location of that opacity?

A Just as Dr. Yannuzzi drew, it is right in front of the posterior capsule in the central axis.

Q Is that the place that these posterior sub-capsular cataracts have a predilection for?

A Yes.

Q Some questions were put to you by Mr. Rheingold with respect to the endothelium, the pumping mechanism and the failure of that pumping mechanism, as possibly relating to trauma of the surgery. If the endothelium is damaged as a result of the initial surgical procedure, does the pumping mechanism work thereafter?

A Healthy endothelium is why most cataracts over 90, or if you want to quibble, 95 percent -- I hadn't actually figured it out, but I think it is around 95, in other words, one out of 20 doesn't come out well -- this is in a larger series. You can get 40 or 60 or 100 perfect, and then all of a sudden bad luck hits. But -- excuse me. I lost my train there. Would you rephrase that?

Q You were talking about the endothelium.

A Oh, I remember now. The healthy endothelium, this is made up of many -- I guess millions of cells, actually, in a single layer on the back of the eye, they are very

minute, and if they are healthy there are now modern ways -- for instance, a man in the University of Florida has a way of mounting these. He takes a biopsy, you can actually mount them and count the cells.

THE COURT: Excuse me, Doctor. I think the question was, assuming that the endothelium is damaged during the operation, for example, due to being touched by instrumentation, does the trouble evince itself immediately after the operation or is there a delay --

THE WITNESS: It clears within a week or two, and sometimes within a day, depending upon the amount of trauma, how much you had to irrigate, whether for instance -- in the days we used capsule forceps, the back of the forceps always touched the back of the cornea. The normal endothelium regains and pumps out and is clear in a matter I'd say at the worse of two weeks.

Q Doctor, once that improvement occurs, can it regress, say, a month or two months later and become incapable of pumping?

A No. Not unless another problem came up, such as glaucoma. Glaucoma is terrible for these things.

Q Or some other problem with respect to the cornea?

A Or inflammation, all kinds of things. Herpes,

keratitis.

Q With respect to Mrs. Johnson and specifically with respect to the right eye, did that right eye, that is the endothelium or the fluid or the pumping characteristics of it, did that manifest any improvement in the immediate post-operative period?

A The cornea two weeks following surgery showed a mild striate and a week later that striate had gone, and the only trouble with that cornea was the thickening above. That was present from surgery, and I am sure it was there, and that's what the wrinkle ended up showing.

Q But there was no interferes --

A No, the central cornea had cleared.

Q With the ability to reduce the fluid, is that correct?

A Yes.

Q The subsequent development of a flud pumping problem, or an endothelial dystrophy, whatever you want to call it, is a manifestation of some other entity, is it not?

A Yes. It only showed up more than three months later.

Q Is this at or about the time of the cystoid macular edema?

A It didn't show up -- the cystoid had been present for almost two months. It was only when the vitritis, which comes from the same inflammatory process, and with it the eye rights, et cetera, that's when the cornea started decompensating.

Q Did you on October 31, 1972 or prior thereto, in September of 1972, did you decide to operate on Mrs. Johnson's right eye for the sole purpose of obtaining another $500 fee?

A Of course not.

Q Have you ever, Doctor, in your medical career operated on a patient solely for the purpose of obtaining a fee?

A No. If I were anxious for money, could have charged her $1000 for the first eye.

MR. BEGOS: I have no further questions.

RECROSS EXAMINATION

BY MR. RHEINGOLD:

Q What accounts for Mrs. Johnson's eye, Dr. Knapp, the right eye, being worse than her left eye today?

A The Irvine-Gass is characteristically assymetrical. One eye or the other can be more involved.

Q Doctor, did I hear you say correctly in answer to Mr. Begos' questions, "As she had four young children,

we agreed to do both eyes"?

A Yes.

MR. BEGOS: I didn't ask that.

MR. RHEINGOLD: I asked if that was an answer that he gave.

Q You said "Yes," Doctor, right?

A Yes.

Q When you say "We agreed," you mean you?

A No. "We" is the whole three of us. They were the ones who brought it up.

A They asked for it?

A Yes.

Q And you acquiesced?

A Yes.

Q Did you tell Mr. Begos that you recall that the subcapsular cataract was in the position that Mr. Yannuzzi drew it on the board this morning?

A Yes.

Q You recall that as of the examination of her in September, 1972?

A I recall it in all examinations prior to October,1972.

Q Including that one of September,1972?

A Yes.

Q Do you recall, Dr. Knapp, that you said when I cross examined you yesterday, you stated that you didn't recall what you saw in her eye as of that date, September, 1972?

A Possibly it is true that my memory has been jogged by the looking at the record.

Q But there is nothing in the record other than PSC, isn't that correct?

A That means posterior subcapsular cataract.

Q Nothing that tells you precisely where it was or how big it was?

A No.

MR.RHEINGOLD: That is all.

THE COURT: Thank you, Doctor.

(Witness excused.)

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D O N A L D J A C K S O N C O L E M A N,

called as a witness by the defendants, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. BEGOS:

Q Are you a physician and surgeon duly licensed to practice in the State of New York?

A Yes, I am.

Q How long have you been so licensed?

A Since 1964.

Q Would you give this Court and jury some of your background, your premedical education, medical education, years of graduation and your post-graduate training?

A My premedical education was in Union College i henectady, New York. I graduated in 1956.

I graduated University of Buffalo School of Medicine in 1960. I interned on the Columbia First Medical Division at Bellevue Hospital from 1960 to 1961. I then entered the United States Public Health Service from 1961, July 1st, until 1964. At that time I was engaged in research in cardiovascular physiology, in physiological optics, and in the use of ultrasound.

Q Why don't you tell us what those areas involved, just briefly?

A Well, briefly, I was engaged in an area called biomedical engineering. I devised techniques for measuring children's cardiac sounds in screening programs, I devised computer techniques for being able to evaluate heart sounds for national screening programs.

I was an instructor in the electrical engineering school and I was also working on a Ph.D. in cardiovascular physiology at the George Washington University on a part time basis.

My experiments with ultrasound had to do with evaluating animals to determine the basis of cardiac function studies, based on movement of heart valves and the ways of evaluating these valvular motions by using high frequency sounds.

As a matter of fact, this area of physics become so intriguing to me and the optics are so similar between acoustic and optical transmission, that I became interested in the field of ophthalmology and it was at this point that I left the Public Health Service and came to Columbia University, the Institute, and I took a residency in ophthalmology at the Edward S. Harkness Institute. That was between 1964 and 1967.

All during that time I was supported by a National Institute of Health special training grant, and

I had my own research grant at the time, continuing to do work in ultrasound.

Q While you were undertaking this residency training program in ophthalmology?

A Yes.

Q Upon completion of that residency training, did you become certified in ophthalmology?

A Yes. On finishing my residency, I became intereste specifically in the field of retina, and I entered an association with Dr. Charles Campbell at the Institute and worked with him for 18 months devoting my attention primarily to retinal disease.

Q Would it be fair to say, Doctor, that you have a subspecialty in retinal diseases in the field of ophthalmology?

A Yes. I am a member of the Retina Society, which is an elected group of retina specialists in the United States. We number 115. We are admitted only on acceptance by our peers in the retina field. It includes, I think, the most -- most of the retina surgeons in the United States.

Q That is not an organization that you can voluntarily enter, is it?

A No.

Q Doctor, have you published any articles in the field of ophthalmology?

A I have published approximately 80 papers relating to ultrasonic evaluation of the eye, vitreous surgery, retinal detachment surgery and phako emulsification of the lens.

I have also been asked to submit chapters to approximately 11 -- approximately 11 chapters in different textbooks. I have one book in press and another in preparation.

Q Doctor, you have been present for most of the testimony in this case, have you not?

A Yes, I have.

Q Doctor, rather than me asking you specific questions, would you tell this Court and jury when you had first seen Mrs. Johnson, what your examinations and findings consisted of, and relate that to her condition?

A My first examination of Mrs. Johnson was on February 22nd of 1972. At that time Dr. Knapp had examined Mrs. Johnson and felt that there was a retinal problem called cystoid macular edema.

He called me on the telephone and asked me to see Mrs. Johnson on that same day, which I did. I

then discussed the problem with Mrs. Johnson and her husband and took them back down to his office where I discussed with him --

Q When you say his office, you mean Dr. Knapp's office?

A Dr. Knapp's office, where we discussed the type of disease and the form of treatment which I felt might be of help --

Q When you say "we," is it "we"?

A The "we" is Dr. Knapp, Mr. Johnson, Mrs. Johnson and myself.

Q Were Mr. and Mrs. Johnson present when you had this discussion with Dr. Knapp?

A Yes.

Q In his office?

A Yes. At that time they agreed, by "they", Mr. and Mrs. Johnson agreed that they would like the attempt at photocoagulation of at that time possibly both but specifically one eye, in an attempt to retard the progress of this disease.

If I could, I would like to show a couple of slides, your Honor, to specifically describe what this disease is. I know Dr. Yannuzzi had mentioned this morning what cystoid maculopathy is, and you have all

heard reference to the Irvine-Gass syndrome, but if I could show a slide of the original subscription of Don Gass, I think it might be of help in describing the program.

THE COURT: All right.

(Pause.)

THE WITNESS: My reason for showing these pictures are that Don Gass, whose name has been associated with Irvine-Gass syndrome, first described this in 1965 and it was first written up in 1966.

What I thought I could do, since it won't show up too well, if I could just pass the original photograph, your Honor, they could look at this and get a little better understanding from that.

The photographs I am going to show are taken from this textbook.

THE COURT: Any objection?

MR. RHEINGOLD: I have no objection, your Honor.

THE WITNESS: You can look at the photograph as it is passed around, but what I am showing you is the back of the patient's eye on the left. On the left you see the back of a patient's eye. This pattern right in here is the pattern that a typical cystoid maculopathy has. This is a drawing of a really ideal case. It shows

this rounded cystoid lattice-like or cobweb appearance to the back of the eye.

On the right is a blowup of this pattern in which a line to the left of light is showing through that cystoid area. What you see is a separation of the inner wall of that cyst, the light going through the clear area and showing up in the back of the eye in the region of the pigment epithelium.

What this means is that fluid has separated the layers of the retina, and that fluid gives an inner wall and a posterior wall. As long as the fluid is in the inner layers, this condition still may be reversible.

One of the ways of diagnosing this disease that has made it so much better understood in recent years has been the use of intravenous fluorescein. This is a dye we inject in the patient's vein. It immediately goes all through the body, and by using a special lens we can see the dye appear in the back of the eye.

By studying of the outlines of the blood vessels as they become illuminated by the dye, by seeing where the dye concentrates in the retinal tissues, we can understand a great many different diseases. But specifically this disease, cystoid maculopathy has been better understood.

The reason for my doing the test of injecting

the dye in the patient's vein was so that I could determine if this characteristic staining pattern, and this is a picture showing the macular changes, would appear. This is diagnostic for the Irvine-Gass syndrome or we call it Irvine-Gass. Irvine is the first person to describe it. Gass in this article is the one who defined it and defined its incidence in the population far better than Irvine had done before.

This is diagnostic, using this technique. This is a series from that same article showing the fundus picture before we inject the dye.

As the vessels are filled with the dye, the early stages of the dye leaking in the peri macular area. We don't understand what causes Irvine-Gass syndrome. Early it was thought to be related to traction on the macula by the vitreous jelling. Pulling, physically pulling on the inner surface of the retina.

As Dr. Knapp described, when the lens is taken out of the front of the eye, the anterior support for the whole vitreous body moves, and every person who has the cataract extracted has that loss of support.

The vitreous tends to move forward a little bit. Since the back of the vitreous, and it is a finite volume, is in contact with the retina, that separation of the

retina from or the vitreous from the retina can produce a little bit of stress.

So the original concept was that Irvine-Gass syndrome was caused by the vitreous pulling on the macula.

People have claimed that they have seen these traction areas. We always looked for them but we can't always find them.

The other thing that we have always found, now that we have fluorescein, there is this early pattern of leakage of fluid in the peri macular capillaries. It can be a large area like this or as in Mrs. Johnson's case it could be a smaller area.

In a later stage, this is a period of roughly 10 minutes' time from this photograph down to this one, we see that the dye concentrates in this cystic area in the center. So the leakage of fluid is one from the peri capillary, peri macular capillaries, into an area just over the area of central vision, the macula now, this is just outside the macula, and now it is going into the macula. That is where the fluid tends to remain.

This is a cut section of a retina, of a patient. We very seldom get tissues like this because patients do not die with this disease. But this was a patient who had cystoid maculopathy, did die, and this

tissue was obtained.

The thing that has been discussed several times with you is the fact that there are cystoid changes. These are cysts. You see this large rounded area filled with fluid. It appears clear. So earlier when I showed you the slide with the light cut through this area, you could see the inner surface of the retina, a cystic area and then the back of the light came right to this area, the retinal pigment epithelium. As long as this pigment epithelium is intact, then the patient may recover vision. The problem is that as long as this cystic fluid remains and remains in a severe form, then a significant percentage of these people go on to lose their vision because the underlying tissue, the retinal pigment epithelium degenerates from pressure.

People have claimed, Dr. Yannuzzi this morning said that 40 to 70 per cent of eyes will have a cystoid macular edema. He is talking about a transient cystoid change, a transient fluid, a transient edema in the back of the eye.

The number of people who have a permanent visual loss is very low. Perhaps 2 per cent. In between that maximum of 70 per cent or what many of us think is a more realistic figure of about 40 per cent are the

number of people who tend to recover from this disease without a permanent visual loss.

But the situation we have here is one of that 2 per cent. We can get an idea of which patients are going to recover by this severity of visual reduction. In Mrs. Johnson's case, she went from 20/30 vision, which is good vision, in each eye, after the operation she had good vision in each eye, and then the vision went down until when I saw her it was I believe 20/200 in one eye and 20/80 in the other, there was a significant reduction, and a bilateral significant reduction.

Therefore, the question comes, if the patient is really incapacitated by this macular edema, what can we do for her. There really is no treatment that can be offered for macular edema of this type. There are two or three things that have been tried. One is the use of steroids, and Mrs. Johnson already was on local steroid drugs.

The second is the use of photocoagulation, which in 1972 we were using on selected patients in the hopes of doing it in just the right manner, and I will describe that in just a moment, and in just the right manner it may help.

Third, and more recently, have been the studies

that Dr. Yannuzzi mentioned this morning, studies on the inflammatory nature of this disease and the use of anti-prostaglandin medication to try to retard his progress. His studies recently completed have indicated that that doesn't work either.

At the present time, three years after Mrs. Johnson developed the disease, we still have no clearcut idea of the cause nor do we have any effective therapy. This is a photograph of the fluorescein angiogram taken by Dr. Sears. I didn't take photographs at the time I examined Mrs. Johnson for two reasons. One, she had a disease in both eyes. The way we generally diagnose this disease is to look in as the fluorescein is going through the eyes, and with a blue filter, in front of an indirect opthalmoscope, we can see the dye appear.

If we are using a camera, we can't follow both eyes. By looking in we can follow them both very quickly, so it would mean a better ability to diagnose the condition.

Secondly, at that time there were many of us who were using photocoagulation but only using it in a manner that would very likely treat the areas of the early fluorescent changes. I am talking about this type of change right in here, the rather immediate

peri macular capillary flush, not the area of central vision in the macula.

By injecting dye just before the photocoagulation, we can see exactly at the time of the treatment where the dye was leaking, treat those areas, as long as they are outside the macula, and the dye itself has a greenish color.

The laser we are using then tends to heat up the walls of these cystic areas more than it would otherwise. So that is why photographs were not taken then. So I cannot show you that.

These photographs here were taken by Dr. Sears in September, and these show the early changes and the late, all indicating that there is a retinal pigment epithelial change.

In other words, the pigment below the cysts has gone on to develop a rather diffuse mottling, indicating a slight progression of the disease. This, to give you an idea of comparison, is a normal fundus, the optic nerve, the retina and the macula area. If I could have the slides that I believe you have, Mr. Rheingold, of Dr. Sears', these show a fundus picture to compare with this one of Mrs. Johnson's left eye. This photograph is dated September 26, 1973, left, and it is a little

darker, but if you hold it right there I think it will be fairly clear.

The thing to notice is this: Here is the edge of her optic nerve. This is the macula, this area right there. This area was not treated, of course, because that is the area of central vision. But this area is showing a bit of progressive pigmentary change. The area in here that I treated is right down here and right there, barely detectable, and if we could project this on a good screen, you can just barely see where treatment was afforded.

Our reason for treating, again, out here is that this provides no change in central vision. But this is where the beginnings of this fluid start. This treatment is effective in my series, the way I have done it, and I no longer do it, but it was effective in three out of the four cases that I tried.

Mrs. Johnson, I feel, is the fourth case. The reason it is effective is that if we do it in an early situation before these retinal degeneration changes take place, blocking off that fluid, it prevents the further deteriorative changes.

The other reason it is effective is by using

the dye itself to help concentrate the energy on the walls of the cyst and the outer capillary area, it tends to increase the heating of this area.

I would like to show other slides, if I can, from Dr. Sears' collection here. I would like to show a slide, Mr. Rheingold, if you agree, of the cornea of the left eye and the cornea of the right eye?

MR. RHEINGOLD: Yes. There were four slides, your Honor, of the exterior of the eye. I would like all four shown.

THE WITNESS: I will be happy to do it.

A This is the cornea of Mrs. Johnson's left eye in a photograph by Dr. Sears taken in September of 1973. This was a period of about seven months after I saw her. This cornea on this external photograph is quite clear. This is a peripheral iridic to me, the type we routinely do for the reasons that Dr. Knapp explained in trying to prevent glaucoma.

The pupil is quite well dilated, the cornea is quite clear. At this time, her vision from the records we have from Dr. Sears is 20/50.

MR. RHEINGOLD: Yes.

A If we look at the same cornea using what we call a slit lamp, we can get a view of the inner surface.

This is much more difficult to appreciate in a lighted room, but this slit of light is going through the cornea, and we evaluate -- the technical word is parallelo piped.

As this light goes through the cornea, it illuminates the outer layer, stroma, endothelium. We can evaluate when looking along the surface whether or not there are changes in the endothelium. At the time I saw Mrs. Johnson in February and March, there were no changes of the endothelium. In Dr. Sears' record he indicates that when he saw her on June 27th, that there were some very early changes, what he called corneal guttata of this inner surface.

Even in September, looking at the photograph, looking at the photograph, we can't detect that. But that doesn't mean we shouldn't accept Dr. Sears' word, because by looking in with a slit lamp he is obviously going to have a better view than we can interpret from this photograph.

Nevertheless, this is a good-appearing cornea. Let's look at the right cornea. This Dr. Sears says is the worst picture of the two of this. This is the right cornea. Notice here -- and this is with her vision at that time I believe 20/200?

MR. BEGOS:

A (Continuing) You can see why the vision is reduced. You see this rather frosted glass appearance of this right cornea; and the reason for that has been described as an epithelial change. The earliest changes that we saw when Dr. Knapp and I examined the patients was called a bedewing. This meant a fluid-like appearance. I call it a chagrin, Dr. Knapp calls it a bedewing. Sort of like the surface of an orange. It has a nubby texture.

As these little bubbles coalesce, larger areas develop and we call them cysts. If the outer wall breaks, then the cornea can become painful. At this point Mrs. Johnson was developing some outer changes, painful cornea. She also, according to the record by this time, had a severe glaucoma. There is a slit lamp view of this cornea too. This is a slit lamp view of that cornea. You can see in the reflected light how this resembles a bit more like a frosted glass.

This is the problem that developed in Mrs. Johnson's right cornea now, the cornea was becoming more opaque and more painful. The reasons that this developed in my opinion were related to changes that developed in these corneas and eventually also even the left cornea is now showing some early changes, are related to a natural

sequence of disease that relate not to the original surgery, but relate to the cystoid macular edema syndrome or the Irvine-Gass syndrome.

I have shown you the changes in the macula that occurred, the picture at the back of the eye and the retina. The reason we call this syndrome is that there are other tissues involved. These tissues are the vitreous and we call that a vitritis or inflammation. The other tissues involved are the cyliary body and the iris, the front of the iris.

In short, any of the tissues on the inside of the eye that are exposed to the vitreous. Once an inflammation develops back here, it can develop here, it can develop on the inner surface of the cornea, which is what we call the endothelium. That is where the cornea problem arises, when the endothelium decompensates. When the inner pump breaks down, the cornea tends to become more opaque. The Irvine-Gass syndrome doesn't by itself involve the cornea. It is only when the cornea is already partially decompensated for some reason that it generally affects the cornea.

What can cause the cornea to decompensate? The two reasons that I feel are active here are, number one, a glaucoma which did drop subsequent to Dr. Knapp's

care, and second, the possibility perhaps of a preexisting relatively poor endothelium, something that we couldn't have known, or no one could see or anticipate at the time, and these two, either or, if they are working together, it could certainly explain why the cornea tends to break down.

Dr. Knapp has testified earlier that the question of why did the right cornea develop this and the left one didn't, it is a variance in the difference between the two eyes. It is just like a person doesn't get grey all at once. Certain parts of the hair get grey before others. One eye can develop more severe changes than the other. If the right cornea, which developed an inflammation at the time of my second examination of Mrs. Johnson, a vitritis and an iritis, once that inflammation developed, all as part of the Irvine-Gass syndrome, then a marginal cornea could tend to decompensate.

Q Are you finished with your statement?

A Yes. I think that I started from the stand to go into my first examination and the type of treatment, and I continued as part of trying to explain what the disease is, talked about the photocoagulation and what I did.

I would like to state that at the time of the photocoagulation, the right cornea and the vitreous had rather suddenly, in a period of five days, shown a severe change. So no treatment was ever made of that right eye using the laser. There is no way of knowing whether the laser treatment of the left eye made the difference and made it improve.

Nevertheless, I feel that it did and her vision had improved from the 20/80 before the treatment to a 20/30, which is significant improvement.

The appearance of the back of that eye had definitely improved, and the cysts -- the appearance of the cysts had all quieted down. This didn't mean that further degeneration couldn't take place. I would also like to point out that this type of treatment, when it has been successful, has usually involved the continuing management and continued photocoagulation.

One of the best documented cases of success using this treatment was that of Dr. Charles Regan, who was acting professor of ophthalmology and acting chairman at Harvard Medical School, Massachusetts Eye and Ear Infirmary. He had found in a woman with a somewhat similar history as Mrs. Johnson, that in one eye following cataract surgery had developed a cystoid macular edema

and vision had been lost, that when the second eye followed the same course, he used photocoagulation early, as I did, and got an improvement. As against the situation here where I no longer had the ability to follow Mrs. Johnson, he was able to follow his patient over the next several months.

What occurs here is that the fluid dries, the macula area clears, but on repeated angiography there are other areas of fluid that reappear, in these peri macula areas.

We are not talking about the macula fluid, but the peri macula area, which can be treated. He used several laser photocoagulation visits and treatments to keep his eye a success. I have no way of knowing whether this might have helped in Mrs. Johnson's case or not, but obviously this could not be followed.

Q Doctor, from reviewing the Yale New Haven records that you had, throughout this patient's subsequent course up until the very recent past few months, was there ever any treatment directed at that left eye and the macula area of that left eye?

A Well, no. Even in ours, there never was any treatment of the macula area. It always has been the peri macula area. Dr. Sears'records do not indicate

any treatment of the back of the eye of any form.

Q Is it a fact, Doctor, that the only treatment rendered to that left eye at New Haven at any time subsequent to the patient leaving your care and Dr. Knapp's care was to supply a soft contact lens to that eye?

A That is true. We must regard that any systemic medication given to the patient is going to affect both eyes. So in point of fact, when she had systemic steroids, they would have affected both eyes. The use of Diamox lowers the presure in both eyes. So from that point of view, she certainly had treatment of the left eye as well as the right.

But in my review of the records, I do not recall seeing any treatment other than the topical bandage contact lens and superficial treatment such as drying the conrea with a hair dryer, and that type of thing.

Q Doctor, is it your opinion that this bilateral cystoid macular edema had some effect on Mrs. Johnson's right cornea?

A Yes.

Q Could you elaborate on that?

A My feeling is that this is really part of the syndrome, of the Irvine-Gass syndrome. The right eye, as I noted, developed a vitritis, you could call it a

uveitis, those terms have both been used here and for simplicity we could consider it a uveitis, that means an inflammation of the uvea, inside the eye, there was an inflammation in the uvea, inside the eye, that was responding to the steroid that Dr. Knapp had been prescribing, but the last visit that Dr. Knapp had with her, the pressure was slightly -- that she had with Dr. Knapp, the pressure was slightly increased.

When Dr. Sears saw that right eye, the pressure was significantly increased. In fact, one of the problems that he devoted much of his early attention to was the development of glaucoma. He speaks of adhesions.

Q Glaucome is a pressure, is it not?

A Glaucoma is pressure inside the eye. The combination of inflammation and glaucoma are the two things that in my view destroyed the right cornea. My feeling is that it is really related to the effects of basically the Irvine-Gass syndrome, intraoccular inflammation, secondarily the glaucoma that developed, and that pressure destroyed the endothelium.

Q Doctor, how can you explain the development or the involvement of the right cornea so early in comparison to the left cornea?

A This is the assymetric nature of this disease.

There is no way of predicting which eye is going to become more inflamed. I would like to think that by treating the left eye with a laser and quieting the disease down, this may have kept this eye better overall. There is no way of knowing that. I think the only thing we can really claim is that this is an assymetrical disease. Once the inflammation started in the right eye as part of that disease, a chain of events is sometimes set in motion, and it was set in motion here, with inflammation and glaucoma in the right eye, that eye became devastated.

Q I think you mentioned in the course of your description, you mentioned subclinical endothelial dystrophy.

A Yes, I did.

Q Would you expand on that, please, as to what it is and how it had any effect in the case of Plaintiffs' Johnson?

A In trying to explain why a cornea develops a post-cataract decompensation, as happens here, we try to evaluate or we can list the various causes for this. Herbert Kaufman has made a nice summary list that I could show on another side, but I can just do it from memory, I think, just as easily.

Q Who is Herbert Kaufman?

A He is an author of -- he is the professor of ophthalmology at Gainseville in Florida. He is one of the world's experts on cornea. He is an author of a chapter in the text that Mr. Rheingold is looking at, and he has in that text described causes of corneal decompensation.

MR. RHEINGOLD: Your Honor, I do have this book. I don't know if you want it.

THE WITNESS: For the convenience of the jury, I could show a slide just showing the table that he has used.

MR. RHEINGOLD: I can pass the table around. In fact, your Honor, I will offer that chapter as an exhibit.

MR. BEGOS: Your Honor, I object to that. I have no objection if he wants to permit me to offer all the other textbooks I have here.

MR. RHEINGOLD: I will offer this chapter and this whole book. It is on cataracts and abnormalities of the lens by Bellows.

THE COURT: Are you relying on that textbook as part of the basis of your opinion?

THE WITNESS: No. I was going to use that textbook which had nicely summarized the cases of

corneal edema and in slide form to allow the jury to follow the explanation of the corneal problem.

THE COURT: If you are not relying on it as a basis of your opinion or as part of the basis, then I won't permit it.

MR. RHEINGOLD: May I have one more voir dire question, your Honor?

Is there a chapter by you in this book, Doctor?

THE WITNESS: Yes, there is.

THE COURT: The ruling remains the same.

MR. RHEINGOLD: It wasn't really a voir dire question.

BY MR. BEGOS:

Q Just enumerate the causes of corneal --

A The causes of corneal post-operative edema are, number one, a preexisting endothelial change. Every time we remove a cataract from a patient's eye, we always examine the cornea, because one of the major complications is a post-operative corneal change, and much testimony has already been given as to the pre-operative evaluation by Dr. Knapp and others of both corneas. In neither cornea was there any appearance of any unusual change or specifically what we look for is an endothelial dystrophy. This is quite common.

In that chapter and in many other chapters, all of us have found that we cannot always evaluate the cornea adequately to determine if, as Dr. Knapp had testified, the proper number of endothelial cells are present. This is called a subclinical dystrophy. But subclinical, it means that with all our means of clinical evaluation, we can't detect it.

So one of the causes, then, is the presence of a dystrophy, and it may be a subclinical dystrophy. Other causes are trauma. If there is a major disruption of the endothelium, that is at surgery, if an instrument had rubbed against it, if it had too much irrigation so that the cells were washed away, then this could cuase a corneal edema.

In my opinion, this couldn't have been a cause because the cornea cleared, both corneas cleared, after cataract extraction, and vision recovered to 20/30.

I would like to comment on Dr. Sears' testimony that was read.

Q Could I ask you, Doctor, eventually, the loss of the right cornea in this case is ascribed to corneal edema, is it not?

A The eventual loss of the right cornea was, yes it could simply be called a corneal edema, a corneal

opacification.

Q Was any other term used to describe that condition endothelial dystrophy --

A Dr. Sears called it a billous keratopathy in his records.

Q Is billous keratopathy synonymous with endothelial dystrophy?

A No. Billous keratopathy refers to the appearance of the outer or epithelial surface of the cornea. That is where -- and Dr. Knapp testified to this earlier, but just to go through it again, the inner surface or endothelium pumps water out of the cornea and keeps the cornea clear.

When that endothelium breaks down and the pump goes, fluid builds up in the cornea and one of the surfaces affected is the epithelium, the outer surface of the cornea. When this develops those little blisters that coalesce, become bulli, and the outer wall of these bulli break down, that is billous keratopathy. That is painful, that is the cause of the major visual disturbance.

Q What is the underlying cause of the billous keratopathy?

A In this case I submit it is the breakdown of -- we have all agreed it is the breakdown in the endothelium.

Q Is that known as endothelial dystrophy?

A Yes. In this case, yes.

Q Is it also known as Fuchs Dystrophy?

A In this situation we are really -- we would have to go on to a very careful breakdown of dystrophies, but in this situation the term Fuchs Dystrophy would encompass what we are describing, yes.

Q Is basically Fuchs Dystrophy and/or endothelial dystrophy a nontreatable condition?

A Yes.

Q Is there considerable controversy with respect to the cause of endothelial dystrophy?

A Yes.

Q Doctor, in your opinion, did the surgery performed by Dr. Knapp on the first or second occasion contribute to or cause the development of endothelial dystrophy in Mrs. Johnson's right cornea?

A Not directly, but we must say that following surgery -- what we are talking about is a post-operative corneal change. There is no question it did not directly influence it. But we are saying that because she developed -- or I am saying -- the Irvine-Gass syndrome, which is found in aphakic eyes --

Q By aphakic you mean --

A An eye in which the lens has been extracted. In that sense it could be, but, no, the surgery that Dr. Knapp performed certainly did not influence the endothelial dystrophy, the Fuchs, if you will, simply because the vision improved to 20/30, and the corneas were both clear.

So the surgery did not produce it.

Q Can endothelial dystrophy or Fuchs Dystrophy, ic an occur in an eye where no lens has been removed?

A Yes.

Q Maculopathy or involvement of the peri macula area can also occur in an eye in which a lens has not been removed, is that correct?

A That is correct.

Q In the event of it occurring, it would run approximately the same course or could run approximately the same course?

A Yes. I would like to just finish one statement that I started having to do with a statement by Dr. Sears that I disagree with, and since it was read into the court record, I would like to comment on it.

He noted that because the cornea of the right eye -- because the vision went down in January, that this would indicate that the cornea in the right eye

had never recovered following surgery. But Dr. Sears really did not have the record, and he was misstaken because it was not the cornea that caused the vision to go down in January, it was the macular edema. So the cornea remained clear from the operation right through until the time of February 27th.

Q Doctor, when you examined Mrs. Johnson prior to performing the treatments that you just described, did you visualize any guttata in either of her eyes?

A No, I did not.

Q I believe on the slides that you showed of the pictures taken in September, there was no guttata?

A There was none that I could detect, no.

Q In the pathology report of the Yale New Haven Medical Center for the corneal transplant in January, that is the first transplant in January of 1974, do you recall reading that pathology report?

A Yes. That was an operation I believe performed on January 4th or 4:00 a.m. in the morning of the 5th of 1974, at which time a button, the cornea of Mrs. Johnson, was removed and replaced with a donor cornea. The pathology report of the cornea taken from Mrs. Johnson showed a -- and I have reviewed that cornea with a pathologist at the Harkness Institute --

MR. RHEINGOLD: That is a bit too far, your Honor. I object to third party conversations.

THE COURT: Sustained.

A (Continuing) -- that report stated that there were no Hassle-Henle warts on the Descemet's membrane of that cornea, and these are the warts that we see with guttata.

Q In other words, the pathologist at Yale New Haven in January of 1974 did not describe any guttata in the corneal button that was removed for transplant?

A That is correct.

Q Doctor, based upon your experience, do you consider yourself competent in examining a patient's eye such as Mrs. Johnson to detect guttata?

A Yes.

Q Doctor, can guttata, based upon your experience, arise as a result of a pressure change in the eye?

A Well, again, glaucoma, which is the pressure change in the eye, can cause a decompensation of the cornea, the corneal endothelium.

Yes, in my opinion, that would precipitate a subclinical dystrophy into a clinical dystrophy with guttata.

Q There was such a pressure change manifested between Dr. Knapp's last visit with the patent and Dr.

Sears' first examination of the patient?

A I believe that -- yes. The answer to your question is yes, but I believe there is a very early suggestion or change in Dr. Knapp's last visit. It was not significant, but it indicates that the base of the pressure curve right had started at that time.

Q I believe Dr. Knapp described it as the upper limits of normal?

A Yes.

Q And that he put the patient on Diamox, and that when Dr. Sears saw the patient on June 27th that it had risen to 27?

MR. RHEINGOLD: Objection only that it was Epinol and not Diamox.

MR. BEGOS: I stand corrected, if that is so.

MR. RHEINGOLD: I think that was a question. I didn't hear any answer to that question.

THE COURT: Did you answer the question?

THE WITNESS: I thought I said yes.

THE COURT: The question was amended to substitute one drug for another.

MR. BEGOS: I wasn't really framing the question for the drug. I withdraw from the question that portion of whatever medication the patient was put

on. Is the answer to the question yes?

THE WITNESS: Would you mind reading the question back.

(Record read.)

A (Continuing) Yes, is my answer.

THE COURT: Let's take our afternoon break now.

(Recess.)

BY MR. BEGOS:

Q Doctor, in 1972 were you doing cataract extractions?

A Yes.

Q Was your method and manner similar to that method as performed by Dr. Knapp in this case?

MR. RHEINGOLD: I object, your Honor. I would rather hear the witness say what it was he did.

THE COURT: Yes, sustained.

A My method of cataract --

THE COURT: Let him ask another question.

Q What was your method of cataract extraction?

A My method of cataract extraction is very similar to Dr. Knapp's --

Q How does it differ?

A -- but there are some slight differences.

Primarily in the use of sutures, suture types,

and I believe in 1972 I was doing phaco mulsification as well as a separate type of cataract extraction, and so had switched to doing both types under microscope, but that is the only real difference.

Q Phaco mulsificiation, Doctor, what is that?

A An alternate technique of removing the lens that I personally believe is not quite as good as the intracapsular cataract extraction, but is preferrable in certain situations. It is technically an extracapsular operation, where we make a very tiny incision into the eye, open the anterior capsule. It is like taking the inside of an orange out and leaving the rind, rather than taking the whole orange out. We open the anterior capsule, put the instrument in, use ultrasonic fragmenting, it sucks it out through that tiny 2 milimeter opening. It means a shorter recovery time for the patient. They can go home the next day and go back to work the day after that.

But it is an extracapsular operation, and it does involve a significant number of reoperations to go in and open the posterior capsule that is left intact.

Q Was it standard practice at Columbia-Presbyterian in 1972 that where some unexpected complication or event occurred in the course of a surgery, that it would

be described or reported in the operative report by the assisting resident?

A Yes.

Q You were present for testimony with respect to the effect on vision of a posterior subcapsular cataract?

A Yes.

Q Did you hear the testimony of Dr. Plain?

A Yes, I did.

Q Do you agree with Dr. Plain's testimony that a posterior subcapsular cataract would not interfere with central fision, that is fine vision required for reading and/or driving an automobile?

A No, I do not. Dr. Plain really -- I really can't agree with much of what he said. A nuclear cataract, perhaps. But in this type --

Q A nuclear cataract is what?

A That is the cataract that forms in the very center of the lens. It is relatively diffuse. In the drawing that Dr. Yannuzzi made this morning -- could I make a similar drawing again? The important point is that the lens -- and this is the cornea front with the pupil, this is the nucleus, an area right in the very center. The rind or rim around the outside -- nucleus is like the yoke in an egg, the albumin, the

white part of the boiled egg, is a cortex. If a cataract froms in the nuclear area, it has a different effect than a cataract forming in this posterior subcapsular area, which technically is all the way from the equator on this side, this whole posterior capsule leading anterior to it is the subcapsular area. As Dr. Knapp pointed out, the fibers which start growing from up here, as it hits the back of that where the physiology is the weakest, this is where they generally start to deteriorate and go. Right in the very back.

Q The center back?

A The center back. Optically this is near the nodal region of this lens. Gullstrand won a Nobel Prize in 1934 for describing the optics of the yee. He outlined the eye at its various points, the cardinal points, the nodal points, of the optics involved.

The importance here is that a cataract right in this region, the subcapsular area is near the nodal point of this lens system. So that with a diaphragm or iris in front of it and with the light rays naturally being focused by this lens, they tend to be concentrated in this area.

Therefore, this kind of cataract can be much more visually disabling than its real appearance. So we

can look around it, as Dr. Knapp and Dr. Yannuzzi have said, and the concept of making it analogous to a pinhole is technically wrong.

What Dr. Plain said with regard to a pinhole is correct for a clear system. As a matter of fact, we test a patient's vision to find out if he needs new glasses or if his present glasses are correct by putting a pinhole up in front of his eye. If they can see better than they can with the glasses, we know that we can perhaps give them a better glass than they are wearing.

The pinhole effect obviates the astigmatism. Some of the power of the lens in front of their eye let's us know if a better lens would help. The pinhole supposes clear media. Obviously, if a patient has a cataract, that whole pinhole analogy is gone. We no longer can resort to using the pupil as a pinhole. It just doesn't work. It is like putting a pin back in the pinhole. Nothing.

So in this analogy of the pinhole, it is not true. In the posterior subcapsular cataract, they can very much better vision, particularly as they accommodate it.

As Dr. Yannuzzi told you this morning, when you hold something up close, the pupil comes down.

This is a natural method called accommodation. The reason you can see both far and near is that our eye was designed with these zonules, that we have to break them in surgery, you heard talk about breaking the zonules, but the purpose of the zonule in the living eye is to aid in focusing this lens, as they pull on the lens it flattens, as they relax it rounds up. As this rounds up, we have near vision.

At the same time, the mechanism makes a smaller pupilary opening, which helps in focusing. So in near vision, as the pupil comes down, the posterior capsular cataract almost invariably gives us a worsening of the condition, particularly on close work and depending on lighting conditions -- as Dr. Yannuzzi said, I agree with him completely, a bright light or lights from a passing car or reading all affect it unduly in this type of cataract.

Q Doctor, are you familiar with the community standard in this community with respect to bilateral cataract extraction during the same admission of a patient?

A Yes, I am.

Q In 1972?

A Yes, I am.

Q Do you believe, Doctor, that the cataract extractions as performed by Dr. Knapp in October of 1972 on Mrs. Johnson were in conformity with good practice in this community?

A Yes, I do. I could expand on that a little. The basic reason for that is at variance from the point that Mr. Rheingold is making. The point is that cataract surgery was delayed until the better of the two eyes needed surgery. That is when surgery is planned. It is not a question of doing one eye and waiting for the other eye until it is ready. The surgery is discussed and brought up as a question of needing cataract extraction when the patient is debilitated or has difficulty in functioning properly.

That was the situation that I interpret here. Her vision in the better of the two eyes was 20/60. At that point she was a candidate for cataract extractions of both eyes. At that point we take out the less good of the two eyes, leaving her the better eye to recover from surgery, and it is elective after that at which time, as soon as we are sure that the first eye is clear, there has been no operative complication, when the left eye can be operated on -- when the other eye can be operated on.

Q Would you agree with Dr. Knapp and Dr. Yannuzzi in the opinion expressed that in this particular type of cataract as it affected the right eye would interfere with the patient's central vision?

MR. RHEINGOLD: Objection, your Honor. The witness should be asked what he believed not whether he agrees with what other witnesses --

MR. BEGOS: I am trying to abbreviate it.

THE COURT: In view of the objection, you better rephrase.

MR. RHEINGOLD: I haven't objected much, your Honor. It just gets to a point --

THE COURT: I know.

Q Doctor, do you feel a patient with 20/60 uncorrected vision and a posterior subcapsular cataract, with that patient's best corrected vision in the dark at 20/30, would be a candidate for a cataract extraction?

A Yes. The point here is that some patients of any age with that type of vision might prefer not to have an operation, and quite clearly when we say -- when we evaluate the patient, we ask them if they are having trouble, how they are getting along, if they are perfectly happy, then they can wait longer. But if a patient with that degree of vision is having difficulty,

there is no question that that is the point that we would discuss surgery with them and leave it up to them.

Q Doctor, what was your fee for a single cataract extraction in 1972?

A $750 for each eye.

Q What was your fee for a bilateral cataract extraction in 1972?

A It would have been $750 for each eye.

Q Doctor, in February of 1973 when you suggested the argon laser treatment to Mrs. Johnson, was Mr. Johnson present?

A Yes, he was.

Q Did you describe or indicate anything to the Johnsons at that time as to the risks or the reasons for or the recommendations with respect to the treatment?

A Yes, I did. At that time I explained to them what the situation was, that really there was no treatment, that often the eye or usually the eye -- in this case both eyes -- would improve on their own, but that in view of the debility and the type of treatments that were available, we had limited things that we could try. I described each of them. I felt that because of the particular pattern of these peri macular or peri macular or peri capillary changes, that photocoagulation might

have a chance, with very little risk, although there was some risk -- if the blood vessels should be struck and bleed, or if the patient should move and the light strikes the macula, there could be some damage, but with relatively little risk, this might improve vision -- might.

Q Doctor, you were present for discussion with Dr. Knapp with respect to the type of consent or the type of information that he related to Mr. and Mrs. Johnson pre-operatively. Were you not?

A Dr. Knapp's testimony, you mean?

Q Yes.

A Yes, I was.

Q Do you feel, Doctor, informing a patient that there is better than a 90 per cent chance of success in this particular type of surgery and answering any questions that the patient may have satisfies the physician's responsibility with respect to informed consent?

A Yes, I do.

Q That it represents a community standard in that respect?

A Yes, I do.

MR. BEGOS: I have no further questions.

CROSS EXAMINATION

BY MR. RHEINGOLD:

Q Dr. Coleman, in one of your answers you said you disagreed with what Mr. Rheingold has been saying, and then you said that cataracts are done when the patient is disabled.

Do you think I disagree with that proposition?

A Yes, I do. Would you like to know why?

Q No. Would you agree with me, Dr. Coleman, that cataract extraction should be done when the patient is disabled?

A Yes.

Q Would you agree with me that cataract extraction should be done and only should be done when the patient is debilitated?

A If I use the word debilitated as you are now, that is the wrong word.

Q You did use debilitated. Would you rather use the word disabled?

A I would rather use the word disabled.

Q Are we in agreement that they should be done and only should be done when the patient is disabled?

A Yes. I would think that the word disabled could be perhaps better defined.

Q When Mr. Begos was questioning you just now, I believe you said that notwithstanding some people having vision of 20/60, some patients prefer not to have cataract extractions?

A That is true.

Q That is just a correlary, isn't it, to the fact that surgery is done when the patient is disabled?

A That is part of the definition, right. It is the patient who determines whether they are disabled.

Q Would you disagree with Dr. Yannuzzi who said that that is not the main criterion, that what you see in your laboratory is?

A I think that what -- as I understood what Dr. Yannuzzi meant in part of that discussion was that we take into consideration several factors. We take into consideration the patient's acuity, what we can objectively measure, what we can objectively see in the clinical evaluation, and what the patient describes to us as their difficulty with their present vision. That is where the disability comes about.

Q You were not obviously in Dr. Knapp's office in the fall of 1972 when he had this conference with Mr. and Mrs. Johnson about cataract surgery, were you?

A No, I was not.

Q And you have been a defendant in this case up until yesterday noon, have you not?

A Yes, I was.

Q And up to that time, at least, you were preparing to give your testimony, give your defense, along with that of Dr. Knapp, right?

A Yes.

Q And you have accepted what it was that Dr. Knapp has told you, that this patient came in and said she couldn't read a newspaper and she couldn't drive?

A Yes, I did.

Q And part of your testimony today has been based on the assumption that that is a true set of facts, is that right?

A Yes, it is.

Q Let's turn to informed consent.

You gave us a long answer, I think I don't have to repeat it, of what you told Mr. and Mrs. Johnson before you gave laser therapy. Did I understand that is what you said in words or substance, that you had explained to them about the laser therapy?

A Yes.

Q On what occasion was that, the first or second visit?

A That was when I did the fluorescein examination on the first visit.

Q You say that you told them that there were some risks but not great risks connected with this laser therapy?

A I said that there were risks -- in substance I said that there were risks but not great, if it was done properly. Words of that substance.

Q Did you tell Mrs. Johnson that she had an ominous prognosis at that time?

A Well, in substance, I may have.

Q What words might you have used which would have conveyed to her --

A As I stated, I tried to define what Irvine-Gass syndrome is, and that in defining that syndrome, in that group of eyes that doesn't do well, develop a macular degeneration, that is a loss of central vision and it could take place in each eye. I believe without any question that is ominous. Whether I used that word or not, I don't know. I don't recall reading that in her deposition of what I said to her. Where did that phrase come to you?

Q I take that from your interrogatory answers, Doctor. Remember when I asked you what your prognosis

was on the first visit, you answered, "Prognosis: Ominous."

Do you recall writing that yourself?

A Yes, that would have been -- but I might not have told her exactly that word.

Q That was in your own mind?

A Yes.

Q Doctor, I believe you said that about 2 per cent of the people who develop cystoid macular edema have permanent vision loss.

A I think that -- it is one of the statistics -- I did say that, and I think that on an overall basis, based on the fact that of the number of cataract extractions done, and assuming that Dr. Yannuzzi's figures of 40 to 70 per cent all developed the macula changes, the overall vision loss wouldn't be higher than 2 per cent, relating to the Irvine-Gass syndrome.

Q Don't you think that is something that should be told a patient in prospect before he is undergoing cataract surgery, that there is a 2 per cent chance that you will develop a condition which could cause you to have permanent vision loss?

A The point is that there are several things that can produce a total -- let's call it an unsuccessful result. The major ones are hemorrhage, infection, wound

dehiscence or break, getting hit in the eye, falling down, something happening, the sutures breaking. Dr. Plain gave you a list of all the things that can happen. Altogether they comprise about a 5 per cent risk. The major risks of infection and hemorrhage are combined with the macular degeneration, the optic nerve atrophy, flat chamber, and so on, to give the 5 per cent.

I don't think that to specifically describe each one of these is in the best interests of the patient.

Q In fact, do you feel that it is not in the best interests of the patient to mention even the major ones to the patient?

A I feel that in my dealings with most patients, patients wish to know what the odds are, "What are my chances that this operation is going to work."

I give them my best evaluation of what statistics are. If I say someone has a 95 per cent chance of success, I frankly do admit that I am assuming that they are able to understand that that is 5 per cent that are failures.

Q And that those 5 per cent failures are blindness failures?

A Those 5 per cent failures vary all the way from blindness to loss of eye.

Q You mean blindness is the less serious consequence and total loss of the eye is more serious?

A Yes.

Q Did you follow Dr. Knapp's procedures as he stated it back in 1972 of saying, "Do you have any questions," and then waiting for the person to ask the questions?

A I always ask if there are any questions.

Q You told us about some doctor who did a study in which he was treating macular edema and he gave the eye several treatments, do you remember that, and --

A I was referring to Dr. Regan.

Q Yes. Did you say there was something about two eyes and he only had this good success in the second eye?

A In Dr. Regan's patient, the other eye had previously been lost.

Q Loss due to cystoid macular edema?

A That's right.

Q He hadn't been able to treat that in time?

A As I recall, the patient hadn't been sent to him for that first eye. I am not positive of that.

Q Your recollection, therefore, is that the eyes must have been operated separately at different times?

A Yes.

Q When the second eye was being operated on, right after that the patient was sent to him so he could get an early start on the cystoid macular edema?

A My recollection is that when the cystoid edema developed in the second eye, that was when Dr. Regan saw the patient and performed the fluorescein tests and did the treatment.

Q Would it be fair to say that if you know it is coming, you start looking for it, that will give you a head start on being able to treat it?

A That is true. In this situation we had as good a head start as can be obtained. By head start, that means within the first month. For example, here the patient developed -- Mrs. Johnson developed the problem in January when Dr. Knapp first detected it, and she was given six weeks, because often this is transient, and that was ample head start.

Q You are saying you actually treated Mrs. Johnson at the optimal?

A It is a question of judgment. As I said, we don't know and probably never will know whether fluorescein combined with argon treatment has an optimal time. In my estimation of the optimal time, this was the best time to do it, yes.

Q Was it just a coincidence that Dr. Knapp was leaving just at the optimal time for you to take over this patient?

A The leaving had no relation at all to my treatment of the retinal problem. He asked me to see the patient, and it really bore no relation to an optimal time.

Q It was just a coincidence that he was leaving when you started your treatment?

A Yes.

Q This Dr. Regan, you said, when he got to the second eye he gave the person several treatments.

A In the case that he reported,yes.

Q How much time apart were they spaced?

A They varied I believe from four months to about eight months. He followed the patient for I think it was a two years span.

Q There was a case here where I believe -- sometime in April you turned the patient back to Dr. Knapp, is that true?

A Yes.

Q That was April 16th, your last day, is that true?

A Yes.

Q Thereafter according to the records, I will

have you assume, if you don't recall it, Dr. Knapp saw the patient later in April, twice in May and once in June. Is that true?

A Yes.

Q At any of those times did Mrs. Johnson come down and see you? She didn't? You didn't see her during those times?

A I recall a conversation with Mrs. Johnson and Mr. Johnson. I believe, though, it was on the 16th of April. I recall discussing the followup visits with Dr. Knapp certainly on into June.

Q During May and June you rendered no treatment to Mrs. Johnson?

A No, I did not.

Q You didn't even look in her eyes with whatever equipment you have, did you?

A No, I did not.

Q As a matter of fact, Dr. Sears took over on this case about two weeks after the last visit of Mrs. Johnson to Columbia-Presbyterian, isn't that true?

A I believe his first visit was June 27th --

Q The last one to Dr. Knapp was June 14th.

A Then that would be one week.

Q A little short of two weeks, 14 from 27.

A Fine.

Q As a matter of fact, when she left Dr. Knapp's on June 14th, he had put down for her to come back in three weeks, is that true?

A Yes.

Q I will have you assume it.

A I assume that is true.

Q Actually in a shorter time than was intended, she did get under the care of another doctor.

A I assume that is true.

Q Do you fault Dr. Sears for not continuing with laser therapy?

A No, I do not.

MR. BEGOS: I object to the form of that, your Honor.

THE COURT: Sustained.

THE WITNESS: That was not my --

MR. BEGOS: You don't have to answer, Doctor.

Q Did you hear Dr. Sears' testimony when it was read by way of deposition about his attitude toward the use of laser therapy for --

MR. BEGOS: I object.

MR. RHEINGOLD: He just said -- he was telling everything else he felt about Dr. Sears.

MR. BEGOS: I withdraw my objection.

Q Did you either read Dr. Sears' deposition or hear me read it where he said he did not want to use laser therapy and gave his reasons?

A Yes, I did.

Q You yourself have stopped using laser therapy, have you not?

A That is true. The reason I stopped was because of this case.

Q You used it three times with success, used it without success in Mrs. Johnson's case, and you stopped?

A I am saying that it was without success because I don't feel that objectively I can claim there was. However, I personally feel that it was successful. Her vision improved from 20/80 to 20/30.

Q That turned out to be --

A And I consider that success as far as the treatment went, because I couldn't continue to follow here. I can't claim that there was a final success. That is why, not because I felt this treatment was not successful. I think it was.

Q Have you ever written up her case, Dr. Coleman?

A No, I have not.

Q Do you contemplate writing an article about

her case?

A No, I do not.

Q Have you written up your cases, your four cases in general, with laser therapy for cystoid macular edema?

A No, that isn't a sufficient number to form any concrete conclusions.

Q Turning to the question of what went wrong in the cornea of Mrs. Johnson's right eye, did I understand you to say that it could be explained either from pressure or from some sort of endothelial dystrophy?

A Yes.

Q If it was due to the pressure possibility, that, I think, you will concede was the result of the original cataract extraction by a series of indirect mechanisms?

A Yes.

Q If it was due to endothelial distrophy, I believe the term you used, that would again be influenced by the fact that there was a cataract extraction in the eye?

A Yes.

Q You are not saying that to a reasonable degree of scientific certainty that if no one had ever touched

Mrs. Johnson's eye, some sort of endothelial distrophy would set in and she would have that milky right eye that she has today?

A I think we have to consider the course that the left eye followed and the fact that -- but the way, you, in phrasing your question, said that I was taking fault with Dr. Sears. I have not.

Q All right.

A But we have to assume that Dr. Sears' observation that corneal guttata were there subsequent to Dr. Knapp seeing the patient, indicates that there is an endothelial process going on.

Q Doctor, what I didn't understand is, are you saying that there was endothelial dystrophy, whatever you call it, Fuchs Dystrophy, preexisting the time that Mrs. Johnson had cataract surgery from Dr. Knapp?

A I am saying that it is entirely possible, that what we call a subclinical dystrophy could have predated. That is one of the causes of a corneal opacification following surgery.

Q One of the reasons you are saying subclinical is that would explain why Dr. Knapp perhaps wasn't careless in not seeing it, is that right?

MR. BEGOS: Objection.

THE COURT: Sustained.

Q Subclinical means the doctor can't see it?

A That means that any doctor, that no doctor can see it.

Q But Fuchs Dystrophy is generally recognized, first of all, is it not, as a condition which develops in adults?

A Yes.

Q And is generally bilateral, is it not?

A Yes.

Q And you are not claiming it is bilateral in this case, are you, in Mrs. Johnson's case?

A No. As I said when we were talking about corneas, to go into the exact differentiation of Fuchs Dystrophy and endothelial dystrophy and guttata is a rather lengthy thing. I was trying to avoid confusion of the jury in saying that.

Q Would you agree with me it is generally bilateral?

A Yes.

Q You agree with me it is very often able to be diagnosed by doctors using the various tests and devices they have?

A Yes.

Q No one saw any sign of Fuchs Dystrophy or endothelial dystrophy in Mrs. Johnson's eyes beforehand?

A No, they did not.

Q If you had seen something like that, the approach to the operation on the eye would have been different, would it not?

A I don't think it would. I think as Dr. Yannuzzi said that morning, there is no question that noticing dystrophy is their means that we explain to the patient that they don't have that 95 per cent chance of success any more. Their chance of success goes down. But we do not know of a way that will reliably allow us to take the lens out without causing the corneal complications if Fuchs is present.

Q So you praised Dr. Kaufman, I believe you said he is well known.

A Yes.

Q Is he a reliable authority on the subject of corneal edema and cataract extraction?

A In general I think he is, yes.

Q As a matter of fact, his position is chairman of the Department of Ophthalmology at the University of Florida, is that correct?

A Yes.

Q Have you read over in the last few days Kaufman's chapter in this book by Bellows that we have been discussing?

A I wouldn't say the last few days, but I have read the chapter.

Q Are you familiar, if it is true, that he says that in an eye which has endothelial dystrophy, the proper treatment, if cataract extraction is needed, is that in addition to that a corneal transplant is done at one and the same time?

A What he was saying --

MR. BEGOS: Objection.

THE COURT: Sustained. Quote from the book directly instead of trying to paraphrase.

Q I will read you, if I might, your Honor, from page 459, Mr. Begos:

"Cataract and epithelial edema. In our experience, patients without epithelial edema generally do very well with cataract extraction alone. In the face of epithelial edema, however, we feel strongly that the surgical procedure choice is a combined keratoplasty," I am just going to interrupt my reading, Doctor, that is corneal transplant?

A Yes.

Q "And cataract extractions."

A I agree with that completely. The thing that you may not understand that he saying there is that he is saying in that situation that is already an opaque cornea. He is describing exactly the corneal situation that we showed the jury and Judge Conner as existing prior to the corneal transplant that Dr. Sears planned. That is the situation of that corneal disease.

Q If you went into one eye of a patient only, Doctor, and you discovered through doing a lens extraction, that the patient did have a Fuchs Dystrophy that perhaps you didn't know before because it was subclinical, are you saying that in approaching the other eye you would use no different technique?

A Your question is a little -- what do you mean by going into? Do you mean if I operate on an eye?

Q I was speaking quickly. If you are operating upon one eye and as a result of that lens extraction you have some permanent corneal damage which on retrospect at least shows that there is some endothelial disease in both eyes, are you saying you would not use a different procedure in the second eye?

A No, I would not, at the present time. The reason is that we used the procedure for removing a lens that

is optimal in terms of sparing the cornea, and to my knowledge there is no better way than we do for the taking the lens out in the first place.

What you have stated, as In interpret it, is that if we -- after operating on one eye and we found later that there was an endothelial dystrophy in that eye, the only effect that would have is that noticing the other eye also has endothelial dystrophy, we have to tell the patient and be aware that there is a different problem. If that endothelial dystrophy in the other eye is so advanced that we know that the cataract extraction alone has a very poor chance of giving sufficiently good vision to be helpful, that is exactly the situation that Dr. Kaufman is referring to, where perhaps the combined operation would be of value.

Q Wouldn't you want to treat the second eye for its corneal dystrophy before you start going into the eye for a lens extraction?

A You are supposing that, number one, we have a good means of treating corneal distrophy,and that means there are a whole range of problems. If it is just a distrophy without billous keratopathy, which as I explained before means the patient has pain, photophobia, light sensation. Then no treatment is necessary.

The dystrophy itself is just an interference with the vision. There is no treatment of that endothelium that I am aware of short of removing the cornea and giving the patient a graft, a donor cornea.

Q You could try and dry up the cornea, couldn't you?

A But, please, you are supposing a step beyond the dystrophy. You are going on into billous keratopathy. The dystrophy is the endothelium. Until that dystrophy has progressed to the point where the cornea has become swollen, where the epithelium has broken down and formed bulli, we do not have a treatment for the enthelial dystrophy. We can only treat supportively the epithelial changes.

Yes, in that respect, if it has gone all the way to that point, then we would treat the epithelium, of course.

Q Doctor, one last question or two and I will sit down. In Kaufman's article here, does he list as one of the causes of corneal edema surgical trauma?

A Yes, he does.

Q That was on that charge you were going to show the jury?

A Yes, it is. I can still show it, if you would

like.

Q It is the one right here in this book on the top of the page?

A Yes.

Q Third under corneal edema following cataract surgery is surgical trauma, you agreed to that?

A Yes.

Q In discussion of this on page 457 does he say, "We have seen troubles develop from getting the ice ball too near the endothelium, even if the endothelium is not touched, cells can be killed by the cold by surgeons attempting to make sections so scleral that they have excessive bleeding which damage the cornea, and irrigating solutions being used which were not properly controlled, so that the corneas become cloudy," and then there is a big parenthesis I won't read, and a period.

A Are you asking me a question?

Q Yes. Do you agree or disagree with that statement?

A I would agree if you would allow me to read two paragraphs also from that same section, without even closing the book. The section preceding it. Without changing the page, I would like to read this in addition.

Q I am going to let you read it, Doctor, but you agree with what I have just read?

A Yes, I do, if we understand the context of the sentences that just precede it.

"In the patient who develops corneal edema after cataract extraction, there are many causes, but three possible causes for the edema require primary consideration. The first is the possibility that the inevitable trauma to the endothelial cells by surgery will hasten the progress of the endothelial disease. The second is that more extensive surgical trauma to the endothelium may in fact wipe off the fragile endothelial cells in large areas of the cornea and cause an acute trauma corneal edema."

The point from reading this is really to point out that this more extensive surgical trauma is what you are describing, and what Dr. Kaufman has described in the section that you read is a traumatic change that would immediately become apparent as a major change. It wouldn't heal so that the patient would have 20/30 vision, and in this case the months of December and January.

Q That is what you say, not what Dr. Kaufman says.

A Well, do you want to read on a little further?

Q I don't really, Doctor, but if there is a place there where it says that --

A The point he said the damage can take place if the ice ball does not touch, what he is expressing there and the thing that you went into with Dr. Knapp had to do with the amount of cooling that can take place between an ice ball and the endothelium. As you know, cold, as Dr. Knapp said, is transferred, or heat, which is the reverse, by radiation, and by thermal conductivity. In this case we are talking about the thermal conductivity. It is very low in air. So that a significant effect on the cornea produced by the ice ball coming even close is not obtained. That could produce this kind of corneal problem that you are suggesting.

Q Then you disagree with what I read to you?

A No, I disagree with the interpretation you put on it.

MR. RHEINGOLD: That is all the questions I have.

THE COURT: Any redirect?

MR. BEGOS: No, I don't think so.

THE COURT: Thank you, Doctor.

(Witness excused.)

THE COURT: I believe you have only one more witness that you anticipate having on Monday, is that

correct?

MR. BEGOS: Yes. I am awaiting some records that won't take long to produced.

THE COURT: I am involved in other matters tomorrow all day long, so we will recess until 10:00 o'clock on Monday morning. We will not be in this courtroom on Monday. We will be in room 619. As soon as we recess this afternoon, my deputy clerk will take you to the sixth floor to show you where courtroom 619 is so that you will know how to find it on Monday morning. It is tucked away in a corner of the building where it isn't easy to find.

We will see you on Monday morning at 10:00 o'clock in room 619.

Have a good weekend. In the meantime, don't discuss the case with anyone else, not even your fellow jurors.

(Court adjourned.)

US v Johnson 74 Civ 5437 5/3 Dr. Rizutti

Anna R. Johnson and Robert K. Johnson

vs 74 Civ 5437

Phillip Knapp and D. Jackson Coleman

New York, New York
May 3, 1976

(Trial resumed.)

(In open court, jury present.)

A. B E N E D I C T R I Z Z U T I,

called as a witness by the defendants, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. BEGOS:

Q Dr. Rizzuti, are you a physician and surgeon licensed in the State of New York?

A Yes, I am.

Q How long have you been so licensed?

A Since 1934.

Q Would you tell the Court and jury something about your premedical and medical education, post-graduate training?

A Well, after graduating college I went to the Long Island College Hospital, which is now known as the Downstate Hospital.

Then I served a two-year general internship, and I took a one-year post-graduate course in diseases and surgery of the eye.

Then following that I spent two years at the Brooklyn Eye and Ear Hospital as a resident in ophthalmology.

Following that I spent one year of fellowship in ophthalmology at the medical school, and then in 1941 I went into the practice of ophthalmology.

Q Are you board certificated in ophthalmology?

A Yes, I am.

Q Doctor, have you specialized in any area of ophthalmology?

A I have done all types of workin ophthalmology, but specialized in diseases of the cornea and surgery of the cornea.

Q Is that any particular portion of the eye?

A Yes, that is the front portion of the eye, which would correspond to the watch glass on the crystal of my wristwatch.

Q In addition to specializing in diseases or treatment of the cornea, have you done work with respect to the lens?

A I did, yes. I have.

Q Doctor, have you published any papers,

articles or books with respect to your area of specialization?

A Yes. I published about 60 papers, and a couple of chapters in different textbooks pertaining to cornea, to cataract and to glaucoma.

Q Doctor, your publications, the 60 publications that you just referred to, would that be in your sub-specialty area?

A No. I say it is cataract, the cornea and glaucoma. Those three categories.

Q In your years of practice, have you had and do you still have a medical school teaching appointment?

A I do, yes.

Q At what institution or institutions is that?

A Presently I am a professor of clinical ophthalmology at the Mt. Sinai School of Medicine, New York.

Q Prior thereto?

A I was clinical professor at the New York Medical College.

Q Doctor, as part of your medical practice since 1941, have you performed cataract surgery?

A Yes, I have.

Q Have you performed that surgery in this country?

A In this country, yes, I have.

Q Have you performed it elsewhere in the world?

A Yes. I performed it in about 24 different countries in the world.

Q Under what circumstances did you perform cataract surgery outside the territory of the United States?

A Trying to teach new ideas in cataract and glaucoma and corneal sugery in developing countries, under the auspices of the International Eye Foundation, of which I am on the advisory board.

Q Doctor, in your career, approximately how many lens extractions have you performed?

A I would say over 3,000.

Q Doctor, have you performed bilateral lens extractions during the same hospitalization?

A Yes, I have.

Q Doctor, what was the practice in this community in 1972 with respect to bilateral lens extractions?

A I think that in some of the larger institutions, it was done rather frequently by many of the ophthalmic surgeons.

Q First of all, with respect to yourself, what percentage in or about 1972 of bilateral lens extractions during the same hospitalization did you perform in your private practice?

A I would say between 50 and 60 per cent.

Q Doctor, what is the criterion for bilateral lens extraction during the same hospitalization?

A The reason for that is several. In the first place, I think it is less shocking to the patient to have just one hospitalization instead of two. From a financial viewpoint, it has advantages. From the question of family care, sometimes you don't have the proper family care, there is a distinct advantage. But, most importantly, I would say that you have a very happy patient, because if you operate on just one eye and that eye cannot function in unison with the opposite eye, it is just like having a strong horse and a weak horse, you can't get along.

The result is that the patient is dissatisfied and you would then have to insist on a contact lens, but many of my patients refuse to wear a contact lens. So I usually carry on with a bilateral cataract operation, but, one week apart.

Q Doctor, with respect to contact lenses in 1972, was there some degree of difficulty with some patients in adapting to a contact lens?

A Yes. The reason for that is that just recently we have come out with a soft contact lens, which causes

very much fewer difficulties and irritation to the eye. But when an eye has been operated upon, and we were using at that time mostly hard lenses, not everyone could be adjusted to that situation.

Q Doctor, is a patient's state of equilibrium or tranquility a factor with respect to adaption to contact lenses?

A Yes. That is very important, because one has to be highly motivated and be of very placid nature in order to wear a contact lens.

Q The contact lens, I assume, is used to restore binocular vision?

A That is a purpose, providing that the vision in the other eye, however, is within normal limits.

Q What do you mean by within normal limits?

A I would say that there shouldn't be any cataract changes in the other eye, because if there are then that will go against attaining binocular vision.

Q Doctor, what type of cataract change in the other eye would mitigate against obtaining binocular vision?

A It could be almost any kind. It could be in the front, in the center, in the back of the lens, which cuts down on the vision of the patient.

Q Doctor, sometime in the recent past I presented Dr. Knapp and Mrs. Johnson's records to you, did I not?

A You did.

Q Did those records include Dr. Knapp's office records, the Columbia-Presbyterian Hospital records, Dr. Sears' office record and the Yale New Haven Medical Center records?

A Yes, it did.

Q Doctor, in reviewing Dr. Knapps records and the Columbia-Presbyterian Hospital records, did you note that bilateral cataract extraction was performed on Mrs. Johnson in October of 1972?

A Yes.

Q Doctor, with respect to visual acuity in Mrs. Johnson at the time or just prior to the time of performance of that surgery, was that surgery as performed in October 1972 in accordance with accepted practices among ophthalmologists in this community with respect to bilateral cataract surgery?

A Definitely, yes.

Q Doctor, the surgery as performed by Dr. Knapp, was that in accordance with accepted practices in the community?

A There is no question of that. Yes.

Q Doctor, in your review of the Columbia-Presbyterian records and Dr. Knapp's post-operative office records, was there any indication in those records of any surgical mishap or unusual trauma during the course of the two surgeries performed on Mrs. Johnson?

A No.

Q Doctor, did you note that subsequent to the patient's discharge from the hospital her vision in both eyes was good?

A Yes.

Q Doctor, good vision in both eyes, would that be an indication of the lack of any trauma to either eye in the course of the surgery?

MR. RHEINGOLD: Objected to as leading, your Honor.

THE COURT: Sustained.

Q Doctor, what would the significance of the patient's post-operative good vision be?

A Repeat that, please.

Q What would the significance of the patient's post-operative good vision be in the post-operative period?

A I would assume that things went along quite normally, in a general course, and the vision that the patient obtained was within the normal range.

Q Do you specialize in diseases of the retina?

A I don't.

Q Is cystoid macular edema, then, one of your areas of specialization?

A Not in the sense of treatment.

Q That is a disease process of the retina, is it not?

A Of the retina.

Q Your area is concerned with the cornea?

A Yes, an intraoccular segment, to be exact. The cornea, the lens and glaucoma.

Q The anterior segment, the conjunctiva, that is the covering of the eye, the cornea and the lens, cataractus lens?

A If you were to cut the eye in three parts, I would say the anterior third would correspond to the anterior occular segment.

The retina would correspond to the posterior two-thirds.

Q Did you know in the records that I submitted to you for review that Mrs. Johnson developed a billous keratopathy in the right eye?

A Yes.

Q What is billous keratopathy?

A The word billous means a bubble or a blister which forms in the cornea because of endothelial dystrophy. The endothelial dystrophy means the back lining of the cornea.

In other words, the cornea, which is roughly almost a millimeter thick, has certain layers. The back part of the cornea, which is the most important, is the endothelial layer. The front part is the epithelial layer. If there is some disturbance for an unknown reason of the endothelial layer, then fluid which normally is present in the eye will seep through the thickness of the cornea and eventually will form a blister on the front of the eye or in the epithelial layer.

If this process continues, then we get scarring and blood vessels start to come in. It is natures way of healing an eye or a cornea. The final picture is one of billous keratopathy.

Q Is there any known cause of billous keratopathy?

A There are and there are not. It could come on spontaneously or it may be related to other conditions.

Q Such as, Doctor?

A Such as injury of the cornea. If you have a laceration of the cornea, you disturb the mechanism of that cornea and fluid will enter. Or you could have

it as a primary condition which is known as Fuchs Dystrophy, which comes on in women, usually, around 40 years of age for some unknown reason and on which no surgery has been done, and you can get a full blown billous keratopathy.

Q This Fuchs Dystrophy, Doctor, does that refer to a condition in an eye in which a cataract has not been removed?

A Yes.

Q The endothelial dystrophy, is that referred to in an eye in which a cataract has been removed?

A Repeat that question?

Q Fuchs Dystrophy is the same process in an eye in which no cataract has been removed?

A Yes.

Q What is the condition in an eye in which a cataract has been removed, an aphakic eye?

A It is more or less similar, except perhaps somewhat more exaggerated when the cataract is removed. If you have billous keratopathy, in my experience, following the removal of the cataract, usually it is much more severe than it is in a Fuchs type of dystrophy.

Q Doctor, is endothelial dystrophy related in any way to pressure changes within the eye itself?

A Yes.

Q Increase of pressure in the anterior chamber is known as what?

A Glaucoma.

Q That is one of your areas of specialization?

A Yes.

Q Are you aware that in Mrs. Johnson, glaucoma developed?

A Yes.

Q Do you have any opinion with respect to the relationship of the glaucoma and the endothelial dystrophy as far as precipitation is concerned?

A One condition actually follows the other. You first start with endothelial dystrophy. Then you have the fluid going through the layers of cornea. You get the epilthelial changes and you get the final picture as I mentioned before of billous keratopathy. The majority of cases of billous keratopathy will end up with secondary type of glaucoma.

Q By secondary type of glaucoma, what do you mean?

A In contradistinction to primary type, an individual whose eyes look perfectly normal, he doesn't know that there is any glaucoma going on, and he reports to a doctor, the doctor takes the pressure and he finds it very high. That is known as primary or the result

of unknown causes for this condition coming on. That is the primary type.

Secondary glaucoma means it is related to an injury, to an operation or to an inflammation in an eye.

Q So that then in addition to a pressure, can inflammation act upon or precipitate endothelial dystrophy?

A Yes.

Q Doctor, in your experience, have you seen endothelial dystrophy develop in an eye following cataract surgery where prior to surgery there was no evidence of any decompensation of the cornea or any endothelial dystrophy?

A Yes. It happens not too infrequently.

Q Do you mean by that that it happens quite often?

A Not quite often, but you do see it, let's say on the average of perhaps 10 per cent of the cases.

Q Is there or was there back in 1972 any clinical tests,medical tests or examination that would reveal to the physician which eye might and which eye might not have some subclinical endothelial dystrophy?

A We have a microscope which we call the biomicroscope or the slit lamp which will give us a

pretty good idea if it is clinically present, that you do have this condition.

Q Is examination or was examination for that condition in the pre-operative period standard back in 1972?

A Yes.

Q Was that a condition that most ophthalmologists could on slit lamp examination detect?

A Yes.

Q Doctor, do you know the defendant, Dr. Knapp, in this case?

A I do.

Q Do you know him to be a competent, capable ophthalmologist?

MR. RHEINGOLD: Objected to, your Honor.

THE COURT: Sustained.

Q Doctor, I want you to assume that Dr. Knapp has given testimony in this case that on slit lamp examination prior to surgery there was no evidence in either cornea of Mrs. Johnson of any billous keratopathy or endothelial dystrophy.

First of all, Doctor, could Dr. Knapp make such a diagnosis on slit lamp examination?

A Yes.

Q Doctor, based upon your previous testimony with respect to the appearance of endothelial dystrophy, I take it that if endothelial dystrophy manifested itself in the subsequent post-operative period, that this could be consistent with pre-operative absence on examination?

A Please repeat that.

MR. BEGOS: Perhaps if I withdraw the question and try to make it simpler --

Q Would the appearance of endothelial dystrophy in the post-operative period in Mrs. Johnson be an indication that Dr. Knapp in examination in the pre-operative period missed some sign of endothelial dystrophy?

A No.

Q Doctor, endothelial dystrophy, when it occurs, or Fuchs Dystrophy, in the unoperated eye, does that have a tendency, that condition, to affect both eyes?

A As a rule, it does.

Q Doctor, does the condition have a predeliction to affect one eye more than the other?

A Yes. It could happen.

Q Doctor, in reviewing the office records and the Yale New Haven medical records, you have seen that endothelial dystrophy did develop in the patient's

right eye?

A Yes.

Q Subsequently based upon your review of the records, did endothelial dystrophy also develop in the left eye?

A Yes.

Q This follows from the bilateral characteristic of the disease?

A That is correct.

Q Doctor, is there any treatment or was there any treatment in 1972 for billous keratopathy and/or endothelial dystrophy?

A It depends on the stage of the billous keratopathy. If the epithelial layer was involved and the endothelial layer was healing, we have certain drugs, certain modalities, to try and dry up the area of the bulli or the blisters that were present which interferes with vision.

Q What medications were available, Doctor, in 1972 to dry up the fluid or the bulli?

A Well, we have a number of them. I could mention the following. We had 40 per cent sugar, 5 per cent sodium chloride in liquid and in ointment form, we had 95 per cent glycerine, and these were the three most commonly used drugs to try and dry up these blisters.

Q Did any of these drugs that were in use in 1972 have any effect on glaucoma?

A No.

Q Doctor, if glaucoma develops, and I take it that in Mrs. Johnson glaucoma did develop in her right eye, if glaucoma develops, what was the treatment for glaucoma in 1973?

A Following cataract surgery, if one develops a billous or keratopathy, such as Mrs. Johnson had, the thing to do is to perform one of two operations; one is known as cyclodiathermy and the other is cyclocryothermy.

Q Would you explain what those two procedures are, how they are done and what they are intended to do?

A Behind the cornea we have a gland which can't be seen by the naked eye. This gland is known as the ciliary body. It is roughly 6 to 7 millimeters in width. This gland secretes an aqueous fluid which goes from the gland, in front of the lens, through the pupil and then through the chamber angle where we have let's say certain pipes that drain the fluid out. This is the normal sequence.

When you have a glaucoma following cataract, at any time the angle of the eye becomes blocked --

Q What do you mean by angle, Doctor?

A It means that the tubes that feed into the angle now are clogged, it is just like a plumbing system, you have to flush them out. But, unfortunately, if you have inflammation, it is difficult to flush them out, and, therefore, you must destroy the gland in part that is producing the fluid in order to control the pressure and to lessen the amount fo fluid.

The pressure will come down, and this will prevent pressure on the optic nerve, which can lead to blindness, if the pressure is sustained very high.

Therefore, in order to do something about this gland, we apply one of two probes. One is a probe that conducts heat, and this is known as diathermy, and it is applied around the eye. Maybe around 12 applications. You leave it on for 10 seconds. and you place it directly over the gland. Then you wait a couple of months and see if -- the pressure usually comes down, but unfortunately, later, the pressure usually goes up again.

I have had occasions where I had to perform such an operation as many as seven and eight times, to keep the eye in a normal intraoccular pressure.

Besides using the diathermy, we can use now a cold probe where you reduce the temperature to about minus 79 degrees Fahrenheit, and by this means you will

destroy the gland and attain the same result.

Q This procedure was available in 1975 with respect to glaucoma?

A Yes.

Q What effect does increased ocular pressure or glaucoma have upon the cornea?

A It keeps the cornea cloudy because there is too much fluid in the cornea. The idea is to reduce the fluid so that the fluid does not interfere with vision. It is just as if you had a raindrop in your eye and you look at objects, and they appear distorted.

Q Doctor, do you, based upon your review of the records presented to you in this case, have an opinion with a reasonable degree of medical certainty with respect to the reasons for the corneal transplant that was performed on Mrs. Johnson at the Yale New Haven Medical Center in January of 1974?

A Yes.

Q Would you give us that opinion?

A One of the requirements when performing a corneal transplant is that you must not have an eye where the tension is too high or too low. If the tension is too high, you must control that pressure by means of cyclodiathermy or cyclocryothermy, and to keep

it within the normal limits without medication for some period of time and then go ahead with your corneal transplant.

Q Doctor, what is the effect of a corneal transplant performed on an eye where the pressure has not been controlled?

A It usually fails.

Q Doctor, is that correct even where the pressure is controlled by medication?

A No. That is not sufficient. We like to control the pressure without medication.

Q Prior to January, 1974 when this first corneal transplant was performed, is there any medication in the records that you reviewed that the pressure in Mrs. Johnson's eye is under control?

A It was temporarily under control with the use of drops, but without drops the pressure went to 30 and as high as 40 millimeters of mercury, and the normal is 20.

Q Following that first corneal transplant at New Haven, the graft did not take, is that correct?

A That is correct.

Q What was the reason for the corneal transplant graft not taking?

A Well, the patient again had the glaucoma condition return.

Q In the course of your practice, Doctor, approximately how many corneal transplants have you done?

A In the neighborhood of about 500. That includes transplants done also outside of this country,however.

Q Is reducing the pressure prior to transplant a condition precedent to doing the transplant?

A That is a universal method of thinking among people who are in this particular field.

Q Doctor, following this first corneal transplant at Yale New Haven, did you note in the records that on two occasions cyclotherapy or cyclocryotherapy was instituted for Mrs. Johnson?

A Yes.

Q Did those two instances of cyclocryotherapy succeed in reducing the pressure?

A No, it didn't. As a matter of fact, after the first one, if I recall, there was bleeding in the eye which aggravated the condition, and the tension was not controlled and it was necessary to perform another similar operation later.

Q That similar operation subsequently, did that succeed in controlling pressure?

A No, it did not.

Q On that second occasion when the cyclocryotherapy was performed, there was also a procedure known as sweeping the anterior chamber?

A Yes.

Q That was performed simultaneously. Would you tell the Court and jury what that procedure is?

A Sweeping of the anterior chamber means that you introduce let's say at the corner of the eye where the brown of my eye meets the white a very thin spatula -- a spatula is a very, very thin piece of metal -- with the purpose of entering the anterior chamber, which is behind the cornea, and going into the angle where there is obstruction and to sweep the obstruction away.

However, this should not be done if you do a cyclodiathermy or a cyclocryothermy because that is injury upon injury. This is why bleeding took place.

Q Did you see, then, in January of 1975 another corneal transplant was performed at Yale New Haven?

A Yes.

Q What was the result of that corneal transplant?

A That also became hazy. Then later the eye went into the opposite state. Instead of having glaucoma, because there was so much damage or injury, rather,

done to the cyliary body -- the cyliary body couldn't function any more and could not produce the fluid and the eye slowly became atrophied.

Q Based upon your review of the records, is there any further surgical procedure and/or medical treatment that can be rendered with respect to Mrs. Johnson's right eye?

A If Mrs. Johnson had at this time normal pressure and was able to tell me where the light was coming from if I move a lit in the corner of the eye, then I would put in a plastic cornea.

Q Doctor, plastic corneas, what is their purpose and effect? Is that to replace the normal, natural cornea?

A The plastic cornea is used in cases where you have previous graft failures, and that will replace the normal cornea of the eye. The advantage is that you do not run into the rejection phenomenon as much as you would if you use tissue from another individual, which is known as a donor tissue.

Q For how long have plastic corneas been utilized as transplants?

A The greatest advantages or rather progress in plastic cornea, which is known as prostokeratopathy

procedures, is within the past 12 years.

Q 12 years?

A Yes.

Q What is the success rate of plastic cornea implants?

A It depends on the condition of the eye prior to the operation. I have had cases where after a seven-year followup in which I performed or rather six operations were performed and vision was still held at about 20/40, but I have had cases where only two operations were performed and I had a rejection after one year.

Q That is of the natural corneal transplants?

A Yes. Usually they have two corneal transplants, maybe three or four glaucoma procedures, the likes of which and nature I just explained.

Q Then they could be candidates for plastic?

A They could be. Usually these are the cases which are referred for this type of work.

Q Do you know Dr. DeVoe?

A Yes.

Q Who is he and in what area does he specialize in?

A He was just recently retired as professor -- not retired -- but I mean he reached a certain age limit,

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he is still very active, professor of ophthalmology at Columbia Physicians and Surgeons Institute.

Q Does he have any specialty in any sub area of ophthalmology?

A I would say that his work is quite similar to mine.

Q He specializes in anterior chamber work?

A Yes.

Q Is tria or striate in an eye, in the post-operative period, an indication of a departure from accepted practice on the part of the operating surgeon?

A No.

Q Is moderate striate in the post-operative period that eventually disappears an indication of a departure from good and accepted practice on the part of the operating surgeon?

A No.

Q What, Doctor, is the incidence and frequency of striate in the post-operative period following lens extraction?

A I would say -- I don't think there are any real statistics taken, but I would more or less take a guess and say about 25 to 30 per cent of cases will show either minimum or moderate striate changes.

Q If that striate goes on to disappear within several days or within a maximum of two weeks of surgery, is that an indication that some departure occurred in the operative procedure?

A It usually clears up after several weeks, two or three weeks.

Q Doctor, I want to ask you some questions with respect to the characteristics of Mrs. Johnson's cataracts, and I hand you Plaintiffs' Exhibit 2-A in evidence, which is Dr. Knapp's office record.

Doctor, would you look at the doctor's records, pre-operative period, from June, 1970 to September 19, 1972. First with respect to the left eye of this lady. Doctor, the progression of vision or the degression of vision in that right eye from the first visit to September, 1972, would that give you or would you have an opinion with respect to the characteristics of that opacity as to whether it was moderate and/or rapid as far as progression?

A In 1970 the vision in the right eye was 25/25 --

Q I am asking about the left eye first.

A The left eye, 20/60 in the left eye, and after a period from '70 to '71 it dropped a few lines to 20/80, and a year later it dropped markedly so that it

was less than 20/200. 20/400 meaning the patient can see the top two letters of the chart, roughly eight or nine feet away.

Q Doctor, could you characterize that progression as slow, medium, moderate, rapid, active, could you characterize it in any way?

A I would say it was medium.

Q Doctor, the cataract in the right eye, would you read the visual acuities uncorrected in the right eye commencing in June of 1970 and terminating in September of 1972?

A From 20/25, which means one line away from normal, 20/20, it dropped to 20/60, in other words, able to read about the third or between the third and fourth line on the chart.

Q In what period of time, Doctor, did it drop from 20/25 to 20/60?

A Less than two years. June, 1970 to September, 1972.

Q Doctor, is there any reading with respect to the right eye following June of 1970? Is there a reading in November of 1970?

A Yes.

Q What was that?

A In the right eye?

Q Yes.

A It was 20/25.

Q So that it remained the same?

A The same.

Q Then on the next visit, Doctor?

A Then it was 20 over 25.

Q So that it remained the same until the next visit, and when was that, Doctor?

A That was less than a year later, it was nine months later, September, 1972, and it had dropped from 20/25 to 20/60.

Q Doctor, could you characterize the degression of vision in that right eye with respect to the character of the cataract?

A I would say it is moderately advanced.

Q Doctor, in your experience in ophthalmological surgery, when a cataract begins to advance or advance moderately, does it have a natural tendency to continue to advance?

MR. RHEINGOLD: Objected to as leading, your Honor. I would like this witness to be the one who it was.

THE COURT: Rephrase the question.

Q Based on your ophthalmological experience, would you tell this Court and jury what the natural tendency of a cataract is that has demonstrated a moderate advance up to a certain point in time?

A Once a cataract starts to advance, such as in this case, it is usually my experience, I find that it will advance quite rapidly in the few months to come.

Q Could it take six months to advance to a point where it would seriously reduce useful vision?

A Well, I can't really answer that in all honestly, but I would say that perhaps definitely less than one year from this time, that it should be quite ripe.

Q Doctor, what are the characteristics of a posterior subcapsular cataract?

A If you consider the lens of the human eye as a lentil, as a matter of fact, it is about the same size of a lentil and that is where the word lens comes from, perhaps, is that it has a front surface and a back surface. If you have a subcapsular cataract, it means that the opacity is in front of the capsule in the back, and the capsule is the lining of the lens. So now we have an opacification in the back portion of this little lentil in front of the outercoat, which is known as the capsule. That interferes with vision much more so than

if it were in the center or in the front of the lens, because the rays of light, as they become parallel, enter the human eye, come to a focus, and they focus on the back part of the lens, and this is why the vision is markedly diminished in contradistinction if they focus on the front part of the lens, because then the light will open up and the vision will be there, to a certain degree.

Q Based upon your ophthalmological experience and in your opinion, would a cataract, a posterior subcapsular cataract in the right eye, that has reduced visual acuity to 20 over 60, would that interfere with an individual's reading ability as far as that right eye is concerned?

A Yes.

Q Doctor, based upon the same set of facts, would the patient's reading ability for normal light or in a normally illuminated room be improvable with lenses?

A No.

Q Why is that, Doctor?

A Because when we read we must have a light. When we have a light in the eye, the pupil constricts. As the pupil constricts, the light rays going through now are definitely blocked by this opacity in the back

of the eye.

Q Doctor, does the posterior subcapsular cataract have a natural afinity to grow or to develop in a certain portion of the lens?

A Yes. I mentioned that it is on the back part of the lens.

Q Where is it with relation to the center of the back portion of the lens?

A If you consider the lens as a bi-convex type of configuration, the posterior portion of the lens would be to my right.

In other words --

THE COURT: No, no. He means with respect to the axis, would it be towards the center or would it be --

THE WITNESS: I see. From top to bottom, as a rule, but you do have a congenital type where it may be just in the center, which is the worst place it could be. But in the usual subcapsular type of posterior cataract, it is from the top of the lens to the bottom of the lens.

THE COURT: I don't know what you mean from the top to the bottom.

THE WITNESS: Okay.

The lens has a vertical diameter.

THE COURT: You mean it starts at the top and grows downwardly?

THE WITNESS: No. It usually occupies the entire back surface, as a rule, more or less at about the same time. The lens is 5 millimeters by 3 millimeters, so that it extends the vertical diameter in a curved fashion, on the entire back portion of the lens.

MR. BEGOS: Your Honor, at this time I offer into evidence the office records of Dr. Pearlstone which were subpoenaed in Connecticut by my office and picked up at the doctor's office in Connecticut on Friday.

(At the side bar.)

MR. RHEINGOLD: I am showing you, your Honor, the records that Mr. Begos has referred to. I don't want to be an obstructivist, but I don't think with one or two exceptions that it complies with the federal rules of evidence as far as what is presented here. However, the card that you have in front of you has writing in various inks as to read matters underlined. I have no way of knowing when it was done or why it was done.

MR. BEGOS: I can assure you that that card and that accompanying letter, as well as a copy of that subpoena, is the way that record was presented to me. I have the individual who picked that record up on Friday

available down here in New York. If necessary I will take the stand and indicate that I did not touch that exhibit and that he certainly will state on the record that it was in his possession and he did not touch it. As far as how they were made or when they were made, I have no knowledge.

MR. RHEINGOLD: I didn't mean to imply and I am not stating that you made any changes. The fact is, in order for this to be a business record, it has to be something that was made by the doctor in the ordinary course of his business and at the time stated. There is no proof about that.

MR. BEGOS: Obviously it is a business record because the doctor had only seen this patient on one occasion, based upon your client's own testimony. That was in February of 1970. He noted his examination, the history and the purpose for me offering this record is to establish the location of the cataract in the eye.

THE COURT: In view of the objection, I can't admit it. It has to be authenticated. I am sorry. I don't know any other way to do it other than to bring the jury in.

MR. BEGOS: I will have to bring him in, then.

THE COURT: We are not going to wait for him.

I have got to finish this case today, as I indicated to you earlier. I have a criminal trial starting tomorrow morning. If you can get him in this afternoon first thing after lunch, I will permit it. Otherwise,I can't.

MR. BEGOS: The doctor is up in Connecticut, your Honor, Fairfield, Connecticut. I will make an attempt, but I am not optimistic that I would be able to get him here.

THE COURT: I am awfully sorry. I don't have any doubt about the authenticity of the record, but where an objection is made, I have to sustain it.

MR. BEGOS: Might I say that with respect to this, I never got an authorization for this particular record. This record and this particular doctor has been available to the plaintiff and plaintiff's attorney since the commencement of this action. If they ever had any doubt about this record of what it indicates or what it doesn't indicate, it was fully within their power --

THE COURT: I agree with you 100 per cent. I don't have the slightest doubt about the authenticity. All I am simply saying is that under the law, where there is an objection about the authenticity, I don't have any alternative but to sustain the objection, do I?

MR. RHEINGOLD: Your Honor, based upon what

you just said and to move this case through to a conclusion, I will withdraw my objection.

(In open court.)

MR. RHEINGOLD: No objection.

(Defendants' Exhibit G received in evidence.)

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BY MR. BEGOS:

Q Would you look at the record of Dr. Pearlstone, and in particular, Doctor, is there any notation on that record with respect to the visit of Mrs. Johnson to Dr. Pearlstone?

A Yes.

Q When was that, Doctor?

A On February 17, 1970.

Q Doctor, does Dr. Pearlstone have a diagnosis or indicate a diagnosis of the condition he found following examination of Mrs. Johnson?

A Yes.

Q What is that diagnosis?

A Bilateral subcapsular cataracts, more pronounced in the left eye.

Q Is there a drawing on that card with an indication or a mark as to the exact location in each eye of these posterior subcapsular cataracts?

A No.

THE COURT: Look at the right-hand side of the sheet in front of you.

THE WITNESS: It often gives you one plane. It is in the center of the lens, yes, but it doesn't tell you if it is in the back or in the front, you see. But the word capsular, I assume that it is in the back.

Q Posterior?

A From his writing there, yes. But from the diagram, it is hard to tell.

Q The dot indicates that it is in the axis?

A Yes, in the axis.

Q Of that lens?

A Yes.

Q The area that would interfere with reading vision?

A Yes.

MR. RHEINGOLD: Your Honor, that is a leading question.

THE COURT: Yes, sustained, sustained.

Q Doctor, was there a practice in this community in 1972 with respect to informing a patient on whom one was contemplating performing a surgical procedure?

A Yes.

Q In particular in this case, bilateral cataract extractions?

A Yes.

Q Doctor, would informing the patient prior to operation that there was a better than 90 per cent chance of success of the procedure and then offering to answer any questions that the patient might have with respect to the procedure, do you have an opinion with a reasonable degree of medical certainty with respect to that type of information given to the patient pre-operatively?

A By telling the patient --

Q Do you have an opinion? Yes or no.

A Yes.

Q What is your opinion?

A By telling the patient that you have a 90 per cent possibility of successful outcome following surgery is a very high percentage as compared to perhaps any other type of surgical procedure that is performed in surgery, on a general level. So that the prognosis is very good in the general type of cataract condition that we operate on.

THE COURT: That is not the question.

The question is whether or not it would conform to accepted practice to tell the patient merely that

the operation had a better than 90 per cent chance of success.

THE WITNESS: Yes, yes, your Honor. I do that in my own practice.

(At the side bar.)

MR. BEGOS: I thought I would bring this up. I have the sister's records, Mrs. Mezzanotte. I should also have under subpoena here the St. Vincent's Hospital record that was supposed to be mailed on Friday with respect to her cataracts. This is Mrs. Johnson's sister, cataract extractions in 1962 and 1971. I would like to offer them into evidence. The purpose is only with respect to informed consent. This lady had it done in both eyes.

MR. RHEINGOLD: I have to read all this. I am not going to just say yes or no.

MR. BEGOS: Can we have our morning recess now? This is my last area with this witness.

THE COURT: Yes. Stick around for a minute. I will tell you about the charge during the break.

(In open court.)

THE COURT: We are going to take our morning break now. Ten minutes.

(Jury not present.)

THE COURT: I have here for you a photocopy of the composite charge insofar as the requests that you made are concerned. Of course, this will be preceded by the usual general comments and it will be followed by discussion of the method of computing damages and a few customary closing comments.

By way of summary, I might say that I am giving the plaintiffs' proposed charges 1 and 2, except for the last sentence of proposed charge No. 2. I am giving the defendants' proposed charges 1 through 4, 7, 14, 21, 24 and 28, with only minor editorial changes, and I am giving the substance of a number of defendants other charges, either as part of the plaintiffs' proposed charges or as part of my normal charges. These are defendants' proposed charges 9 through 13, 17 through 20 and 25 through 27. I am not giving the defendants' proposed charges 8, 15, 16, 22 and 23 because for the most part they are not applicable to the evidence as it has actually gone on.

But what I am giving you will have there in front of you, and you can see from the difference in type where they came from. The plaintiffs' proposed charges were in elite type and the defendants' proposed charges were in pica type.

I have also prepared for submission to the jury a list of questions to be answered by the jury, and I will give you each a copy of that.

MR. BEGOS: That would then satisfy my request, my oral discussion with you with respect to multiple theories?

THE COURT: I have not separated out the question of informed cause. I have included that in question 1, "Did Dr. Knapp fail to use the skill and care of an ordinary ophthalmologist at the time and place in question," and in my charge I will say that one of the ways in which he is charged to have failed to exercise ordinary care was in failing to give the patient sufficient information about the hazards involved to permit her to make an informed choice.

MR. BEGOS: Your Honor, what I was really referring to is that as I see the evidence in this case, there are three possible bases for some finding on the part of this jury. There is one, trauma or unnecessary trauma during operation, which, incidentally, no expert has characterized as a departure. Does your Honor intend to give that issue to the jury?

THE COURT: Excuse me. I didn't understand. I was looking at something else. What issue?

MR. BEGOS: There is a claim that the back

of the cornea was injured with a cryoprobe or with some instrument in the course of this surgery.

THE COURT: I am just going to give that as part of the first general question. I don't think I need to break down into subquestions whether there was any injury to the endothelial layer.

MR. BEGOS: The case of Schreiber against Cestari, which is a New York Appellate Division case, 40 A.D. 2d 1025, I realize I didn't give you this in my written requests, your Honor, indicates that where a case is given to the jury on multiple theories, some of which may have been sustained in the evidence, some of which may not have been proven, that the jury should be given those questions to answer either negatively or affirmatively. The only place that comes into being is with respect to the alleged instrumentation and also the unnecessary procedure. It is not necessary as far as the informed consent.

THE COURT: I think that there is probably enough evidence that a jury might conclude that there was some instrumental injury to the endothelial layer during the operation. The comment which Mrs. Johnson claims she heard, plus the questionmark in the post-operative report, cryoprobe-questionmark, I think is sufficient

evidence to go to the jury.

MR. BEGOS: Then when you consider the evidence and the testimony of all the experts, plaintiff and defendants, not one expert has characterized such a happening, if in fact it did happen, as a departure from accepted practice.

THE COURT: If the cryoprobe in fact touched the back of the cornea, I think everyone would agree that is a departure from accepted practice.

MR. BEGOS: I don't think so, your Honor.

MR. RHEINGOLD: Your Honor, Dr. Plain and Dr. Sears both said you are not to touch the back. Dr. Knapp, as a matter of fact, said the same thing.

MR. BEGOS: Absolutely.

MR. RHEINGOLD: To not do something, Mr. Begos, and you do it, it is wrong to do it.

THE COURT: I think there is enough there to go to the jury.

MR. BEGOS: I would except, your Honor, to that area.

MR. RHEINGOLD: Your Honor, directing my attention, first of all, to the questions to be answered, I would like to discuss No. 2 as to the word blindness. Of course, we do contend that Mrs. Johnson is blind

as a result of the malpractice.

However, it might be misleading to the jury to so simplify it. For example, in summation I will be talking about one eye as compared to the other eye. In one eye she is blind but in the other eye she could see some things.

THE COURT: I will explain that in the course of the charge. I will tell them this is a shorthand way of referring to her condition which is not absolute lack of vision.

MR. RHEINGOLD: As to the proposed charges and those that you also determined not to read, I would like to have a chance to read them all and, of course, take my exceptions and requests at the appropriate time.

However, at this point we did request a charge as to subsequent negligence, and we did hear for the first time this morning, your Honor, testimony that there were a lot of things that Dr. Sears did that were wrong and things that Dr. Sears could have done which he didn't do. I think now the other shoe has dropped and we have the case where they are blaming Dr. Sears, and the law is clear in New York that the original tort feasor is liable for even malpractice on the part of the subsequent treating doctor.

THE COURT: I believe the cases that you cited in support of that proposition were not cases in which the first tort fees or was guilty only of medical malpractice.

MR. RHEINGOLD: That's true. I cited no case -- I cited the usual run-of-the-mill cases like the auto accident which then sends someone to the hospital where the malpractice occurs.

But the principle in law wouldn't make any difference who the tort feasor was. If A injures somebody and puts him in a situation where the patient then goes to treatment to B, and that happened here, where she went to Dr. Sears after receiving the injury from A, then it wouldn't make any difference --

THE COURT: Do you want to comment on that?

MR. BEGOS: Yes, your Honor. I disagree wholeheartedly with that proposition in this case. If the full extent of our proof in this area were to come out, it would indicate that in all probability the condition from which the plaintiff suffered in June of 1973 could have been completely cured.

THE COURT: I think this is taken care of, really, by the second question to be answered by the jury. The question is really whether Dr. Knapp's lack of skill and care, assuming they find that he was

guilty of such a lack, was a competent producing cause of Mrs. Johnson's condition. In determining that, obviously they will have to consider whether or not that condition was caused by something else entirely or whether Dr. Knapp's lack of skill and care was a competent producing cause. It need not be the only competent producing cause. If it set in train a sequence of events which resulted in her condition, then under question 2, why, he is liable.

(Recess.)

(In the robing room.)

MR. RHEINGOLD: Mr. Begos next proposed exhibits with respect to Mrs. Mezzanotte, I am not going to make an objection with respect to authenticity, although it would probably be as good as the last one. There is in this envelope a large amount of things, including an insurance form, unidentified pictures, letters from third parties whose records are not or were not subpoenaed, and, in addition, we are dealing with a nonparty to this case, and where someone is waiving her physician-patient privilege --

THE COURT: She must have already done it, otherwise we wouldn't have the records at all.

MR. BEGOS: The records were obtained under

subpoena.

MR. RHEINGOLD: Mrs. Mezzanotte did not know about this, according to what her sister told me this morning.

THE COURT: I don't know how the physician turned them over just because he got a subpoena.

MR. RHEINGOLD: I suppose he honored the subpoena. That doesn't give him the right to waive someone else's privilege. If I can understand from Mr. Begos what use he wants to make of it, maybe then I will waive my objection.

THE COURT: The use of it he wants to make is obvious. He hasn't yet laid a foundation for it, but I assume he intends to ask the doctor whether or not the fact that the sister had a macular edema following the cataract removal would indicate that Mrs. Johnson was predisposed to have such a reaction.

MR. BEGOS: No. That is not my purpose.

THE COURT: What is it?

MR. BEGOS: My purpose actually is to show on the informed consent issue that for a good number of years Mrs. Johnson must have, and she indicated in her testimony, that she was aware of her sister having had cataract operations, that they live in fairly reasonable

proximity to each other in Connecticut. She developed macular edema following the first extraction, and she developed macular edema following the second extraction, and she had in addition thereto cortisone, laser therapy at the University of Connecticut. That is indicated in the doctor's card and it is also indicated in one of those letters. The photographs that you referred to when I last saw them were enclosed in the letter from Dr. O'Rourke at the University of Connecticut.

That is the sole purpose --

MR. RHEINGOLD: That is not a sole purpose, that is a lot of purposes, Judge.

THE COURT: Are you willing to stipulate that if Mrs. Johnson were recalled, she would say that at the time she consented to the surgery, she was aware of the fact that her sister had complications following cataract removal in each eye?

MR. RHEINGOLD: I have to ask her. I don't know. Also, your Honor, I will be putting her back on the stand as a rebuttal witness.

THE COURT: Would you stipulate that if she were recalled she would testify?

MR. RHEINGOLD: I will be putting her back on as a rebuttal witness to rebut some things that,

Dr. Knapp attributed to her. I will go out and ask her real quick whether she was aware that there were complications. Then, of course, Mr. Begos could ask her that.

(Pause.)

MR. RHEINGOLD: Her testimony would be no, she was not aware of it.

THE COURT: Then it wouldn't make any difference, in any event, then.

MR. RHEINGOLD: If that is his limited use. He also wants to show something about she developed macular edema in both eyes.

THE COURT: He said that isn't his purpose.

MR. RHEINGOLD: He said no, and then when he said what he wanted to, he said yes.

MR. BEGOS: No. What I am interested in, Paul, is complications, post-cararact extraction. There is a lot more in that first record or following that first operation that could be a lot more detrimental to you if I have to go through it piece by piece. She couldn't tolerate a lens at all. Her binocular vision was never recalled.

MR. RHEINGOLD: I can't stipulate to something that is not true.

MR. BEGOS: Suppose we just stipulate that there were complicated --

MR. RHEINGOLD: No, I can't.

MR. BEGOS: And that your client was unaware of the complications --

MR. RHEINGOLD: That makes no sense.

THE COURT: That is not relevant. The fact that you got a bad result in one case is not really relevant. It would be relevant only with respect to showing that Mrs. Johnson knew about it, so she should have been more alert to the possibility of a bad reaction in her own case. Another possibility was the one I originally suggested, that because of similarity in the action by siblings, that it tended to indicate there was no malpractice on the part of Dr. Knapp.

MR. RHEINGOLD: That would require additional testimony that it is genetic or familial --

MR. BEGOS: There is no such evidence, Judge.

THE COURT: I know there isn't.

MR. BEGOS: Even outside of this particular offer, it is not intended for that because there is no such evidence of macular edema, that it has any genetic crossover.

THE COURT: I don't think it is relevant, then.

If her sister didn't know about it, then what difference would it make?

MR. BEGOS: I think it is a question of fact for the jury. If her sister had complications, whether or not this lady --

THE COURT: Whether she should have known about it or would necessarily have known about it despite her protestations to the contrary?

MR. RHEINGOLD: He will have an opportunity, your Honor, to question her. Then he can rebut that with these records, if he wants, at which time I will violently object, of course. The appropriate time to rebut her testimony is after she has said something.

MR. BEGOS: I don't know that she -- that it is proper redirect or rebuttal for you to come back in with respect to --

MR. RHEINGOLD: No.

THE COURT: He wouldn't bring it up, but on cross examination --

MR. RHEINGOLD: If on cross you say, "Didn't you know about all of these horrible things from your sister," she says, "No" --

MR. BEGOS: Is that improper cross on my part?

MR. RHEINGOLD: I don't object to that.

I object to your using this to try and prove she is lying.

THE COURT: I won't admit it at this stage for a number of reasons. One of which is apparently there is no waiver by the patient.

MR. BEGOS: May we have this marked as an exhibit.

THE COURT: For identification, yes.

MR. BEGOS: The entire folder for identification.

(In open court, jury present.)

MR. BEGOS: Your Honor, may he have the record that we discussed at side bar and in chambers marked for identification?

THE COURT: Yes.

(Defendants' Exhibit H marked for identification.)

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BY MR. BEGOS:

Q Dr. Rizzuti, what was the standard fee or what was the acceptable fee for cataract extraction in the New York City area in 1972?

A I believe it was between $700 and $950.

Q Doctor, based upon Mrs. Johnson's vision in September of 1972, the 20/60 uncorrected, do you have an opinion with a reasonable degree of medical certainty

whether a person with such vision in one eye, with vision in the other eye of 20/400 minus, would be capable of driving an automobile?

A No.

Q For what reason, Doctor?

A Well, because in daylight, especially if there is sunlight, the pupil will constrict, and if the pupil gets very small, then the rays of light are going to hit the part of the cataract in the back of the eye and the patient will not be able to drive.

MR. BEGOS: Thank you, Doctor. I have no further questions.

CROSS EXAMINATION

BY MR. RHEINGOLD:

Q What if you measured 20/60 uncorrected in a patient and yet the patient told you that he or she was driving?

A I didn't hear what you had to say.

Q I am sorry. What if the patient says, "Doctor, I can drive," then you look in there eye and the uncorrected vision on this Snellen chart here is 20/60. The person can drive, can't he?

A But you drive dangerously.

Q I didn't hear your answer.

A She would drive dangerously.

Q Is that something within your field of ophthalmology, to be able to know the ability of the person to drive?

A I believe that her vision will drop below the required vision to drive a vehicle.

Q Sir, it depends how the vision is corrected too, does it not?

A No, it doesn't make that difference, because it depends on the size of the pupil in bright sunlight.

Q Many people drive only by virtue of having lenses, don't they? They can't drive if they don't where their eyeglasses?

A Yes.

Q Doctor, do you listen to this patient when they tell you what they can and cannot do?

A Yes.

Q If a patient came to you and they had cataracts in both eyes and yet they could see to do all the things that they wanted to do in their own lifestyle, would you operate on them?

A Repeat that again, please.

Q Do you operate on a patient when the patient complains or starts to complain about his vision?

A Depends on how much of the visual deficiency is present at the time of examination.

Q Would it be true, Doctor, that notwithstanding whatever amount of visual deficiency there was, if the patient could see to do the activities that were satisfactory to her, you would not operate, would you?

A Providing that that patient is willing to go along life that way, I would not operate.

Q You wouldn't cross examine your patient, or try and talk the patient into an operation?

A Never do.

Q If the patient says, "I can see to drive, to read, to do the things important to me," you wouldn't talk that patient into an operation?

A Never.

Q So when you say sometimes 50 to 60 per cent of your patients are bilateral, that is based on a situation both where your reading of the eyes and the patient's complaints line up, isn't that true?

A Exactly.

Q What if a patient came to you who had a cataract only in one eye, it bothered him, he was a truck driver, or something, wanted vision in both eyes, he had a trauma as a child, one eye is perfect, the other eye had a

cataract, you would operate on that one eye?

A In many cases I do.

Q You would be forced to, even though you wouldn't operate on the other eye?

A That is correct.

Q You wouldn't touch the eye without the cataract, would you?

A That is correct.

Q Then you would be faced with a problem that I think you described of having to balance the vision between the two eyes?

A I would tell him about the contact lens, yes.

Q You would attempt to use that method, wouldn't you, the contact lens and the spectacles?

A That is explained, yes, ahead of time.

Q If you were faced with an eye that had a lens out in one and in the other nothing out, then you would do the best you could to give that person vision, would you not?

A Yes.

Q For example, you would try the contact lens?

A Yes.

Q The improvement that we have now with the soft contact lens, I take it more people are able to adjust

to that?

A That is correct.

Q Sir, as a matter of fact, if a housewife came in with a large cataract in one eye, 20/400 vision as a result, and in her other eye she had,to her,satisfactory vision, you probably wouldn't operate at all, would you?

A It depends on what you call satisfactory vision.

Q If she felt that she had satisfactory vision, and she for example did not want an operation on the better of her two eyes, you would not touch the poorer of the two eyes?

A If she told me she did not want an operation, I would not operate.

Q And you wouldn't even recommend to her to touch the poorer of the two eyes, isn't that true?

A It depends on the type of cataract. In a subcapsular cataract, I would advise earlier surgery for the reasons I discussed.

Q That is because if you let it go too long, it might become mature and injure the eye?

A No, because of the fact of the light situation. In other words, when there is too much light, that 20/40 vision will drop down to probably 20/200, or less.

Q That is when the patient becomes dissatisfied

with her life the way it is, isn't that correct?

A Yes.

Q Doctor, you can't say when it is that a cataract that is reading at a correctable level of 20/30 and an uncorrected level of 20/60 will mature enough to interfere with vision, can you?

A Repeat that, please.

Q I'm sorry. It was a poorly phrased question. Can you state from the stand here a definite rate of progress for cataract in the eye?

A It depends on how much progress or how much advancement of the cataract took place let's say within the last two or three months or five months.

Q Sometimes, Doctor, in your experience, cataracts don't progress at a set rate, isn't that true?

A Definitely, yes.

Q Aren't there at least occasions where there is no progress at all for a period of time?

A Yes.

Q Then they speed up again?

A Then they can speed up again, yes.

Q Doctor, you were asked about Dr. Knapp's records and you were asked, I believe, whether the observation of mild or moderate striate in the eye post-operatively

would be a sign that anything went wrong.

Do you remember being asked that?

A Yes.

Q Your opinion was it wouldn't, isn't that true?

A No, there doesn't have to be anything wrong. It still happens.

Q There might be but there might not be.

A Either way, yes.

Q You have apparently terms of gradation; mild, moderate and something called marked?

A Yes.

Q Doctor, marked is more severe than mild or moderate?

A That is correct.

Q When you were asked by Mr. Begos, he asked you to assume that Dr. Knapp saw moderate striate in the eye, isn't that true?

A Yes.

Q Before that, I believe you testified, Doctor, you had read over all these records, isn't that true?

A Yes.

Q As a matter of fact, what Dr. Knapp noted in Mrs. Johnson's eye post-operatively was marked striate, isn't that so?

A That was on the other eye, I believe.

Q The right eye?

A It was on the first eye, which cleared.

Q You say the first operated eye was the one that was marked?

A She had it in both eyes. Yes, the first one, as far as I know, it then cleared.

Q You are saying the right eye was the one that only had moderate striate and not marked striate?

A Moderate in the right eye.

Q Doctor, I am going to show you Plaintiffs' Exhibit 1. You reviewed these Columbia-Presbyterian records, did you not?

A Yes.

Q You probably have a copy of them in your folder here.

A I don't have all of them, no.

Q Do you remember looking over the sheet that I have opened this to where there is a date of 11/1?

A I couldn't hear you.

Q Do you remember looking over the records that are open to you now, Doctor, the entry of November 1, 1972, on the left-hand side of the page where there is a reading about the right eye? The question is, Doctor,

do you remember looking at that before taking the stand today?

A Yes.

Q Does that not state that it is the right eye, the second operated eye, that there was marked striate in the eye?

A Yes. But there is -- questionably, yes.

Q There is a questionmark about whether the cryoprobe was the cause of that?

A Yes.

MR. BEGOS: I object to the form of that.

THE COURT: Sustained.

Q Doctor, just staying with -- it says, so there is no question about it, there is no questionmark anywhere where it says marked striate, isn't that true?

A Yes.

Q That is a degree more severe than mild or moderate?

A Yes.

Q Doctor, you have testified about billous keratopathy. That can, I assume, occur after an operation?

A That is correct.

Q You could have an eye that was perfectly healthy, have none of this Fuchs Dystrophy, or whatever you call it,

but as a result of the operation an unfortunate post-operative complication was the appearance of billous keratopathy?

A Yes.

Q Were you telling us, Doctor, that in Mrs. Johnson's case you can rule out the billous keratopathy that she had as a post-operative complication? Can you rule it out?

A Repeat that again, please.

Q Can you rule out the billous keratopathy that Mrs. Johnson developed as a post-operative complication?

A No.

MR. BEGOS: I object to the form of that question.

THE COURT: Overruled.

A (Continuing) Billous keratopathy can come as a result of the operation or it can come without, any complication from the operation, or from no operation at all.

Q You are not saying, are you,Doctor, that Mrs. Johnson's billous keratopathy occurred without regard to the operation --

A I didn't quite understand the question.

Q Are you saying that Mrs. Johnson billous keratopathy appeared because it appeared without regard

to the operation?

A I don't quite understand that.

THE COURT: What he is trying to say is, did Mrs. Johnson's billous keratopathy appear spontaneously and without any causation or contribution by the operation?

THE WITNESS: Yes, I would say so.

Q It is your opinion that the operation that Mrs. Johnson had had nothing whatsoever to do with the billous keratopathy that she developed?

A No, no. Because it can happen without any complication, but it can happen following cataract surgery.

Q Either way, right?

A Yes.

Q I have to ask you the same question his Honor asked you. Are you saying that it is more likely that it just developed in her right eye spontaneously?

A No.

Q Isn't it more likely that it developed because there was some foreseeable natural trauma to her eye in performing the operation?

A A cataract operation introduces trauma, yes.

Q One of the reasons that this billous keratopathy forms, is it not, Dr. Rizzuti, is that ah inflammation sets in in the eye?

A That was one of the causes.

Q An inflammation was observed in Mrs. Johnson's eye post-operatively, was there not?

A The eye usually is inflamed following surgery, yes.

Q And the inflammation is the result of the surgery, is that correct?

A As a result of the surgery.

Q So the finding Mrs. Johnson's eye post-operatively of glaucoma is also consistent with the fact that surgery was performed on her eyes, is it not?

A The glaucoma came on very late following the surgery.

Q So late that --

A But it was going along with the development of the billous keratopathy, in very later stages, yes, which is usual.

Q It is more likely than not that the operation had something to do with the appearance of the glaucoma, isn't it?

A Well, I would say that the billous keratopathy is the reason for the glaucoma.

Q Glaucoma is secondary to the billous keratopathy?

A Yes, in many cases.

Q The billous keratopathy may be secondary to the inflammation in the eye?

A It may be.

Q Are you critical of Dr. Sears' treatment of Mrs. Johnson?

A From what viewpoint?

Q Do you say that he didn't do what he could have done?

A I feel if I were to operate on an individual, as I had mentioned before, I would like to have the glaucoma under control without medication, and I would institute one or more operations to bring that about.

Q In your opinion, Doctor, did Dr. Sears err in his treatment of Mrs. Johnson?

MR. BEGOS: I object, your Honor. Irrelevant.

THE COURT: I believe it is irrelevant to the issues as framed.

Q Have you ever examined Mrs. Johnson's eyes, Dr. Rizzuti?

A No.

Q Did you ever ask for an opportunity to look at her eyes?

A No.

MR. BEGOS: Objection, your Honor.

THE COURT: Overruled.

Q Do you know what conditions Dr. Sears was faced with in treating Mrs. Johnson, Dr. Rizzuti?

A From my past experience, I have a pretty good idea, yes.

Q You have read over his records?

A I did.

Q Did you read over the deposition he gave, the testimony that he gave under oath? Did Mr. Begos ask you to read the testimony that Dr. Sears gave about his treatment of Mrs. Johnson which has been read to this jury?

A Yes. You mean the folder? Is this something that happened in the last day or so? Is that what you are talking about?

Q I am talking about testimony which he gave on April 9th here in the courtrhouse but was transcribed and then read to the jury the other day, about 100 --

A Yes, I went over that.

Q Did you read in there that Dr. Sears was confronted with a problem of adhesions in the eye?

A Yes.

Q And he felt that the adhesions were one of the reasons that the first corneal transplant did not hold?

A I don't agree with that.

Q Did you read that that is what he said?

A That is what he said. He said he found adhesions.

Q Adhesions are another post-operative complication, are they not?

A They follow with billous keratopathy, not infrequently. The adhesions could come about.

Q So that if we have billous keratopathy as a result of the eye surgery that Dr. Knapp did, then we may have adhesions as a result of that, is that true?

A Adhesions could follow the billous keratopathy. That is probably what caused the glaucoma, yes.

Q You say that may but is not in every case the cause of the corneal transplant failure?

A What?

Q Will adhesions cause on occasion a corneal transplant to fail?

A No. You could have adhesions and not have a failure of the -- you could have a clear cornea.

Q But on occasion, Doctor, adhesions cause a failure of a corneal transplant?

A Very seldom.

Q Don't these adhesions grow over the eye and turn--

A No, they do not.

Q Dr. Rizzuti, Dr. Sears did appreciate that there was a pressure problem, did he not?

A Yes.

Q And he did give drugs to bring it down?

A Yes.

THE COURT: On the second operation or the first?

Q On the first corneal operation. He had given her drugs in advance of the first corneal transplant in order to bring down the pressure?

A Yes.

THE COURT: On the second operation he used cryosurgery.

MR. RHEINGOLD: I will go into that.

Q He did have her pressure down within normal limits, did he not?

A With medication.

Q With medication he had her pressure under normal limits at the time of the first operation?

A Yes.

Q You said that one way to bring down the pressure and hold it down permanently is applying the cold to the cyliary body, isn't that true?

A That is correct.

Q Cyclocrytherapy?

A Yes.

Q He did do that on two occasions, did he not?

A After the corneal transplant.

Q But he did them, didn't he?

A After, but not before.

Q Afterwards, in order to save the corneal transplant, on two occasions he applied this cold therapy, did he not?

A In order to control the tension.

Q And to save the transplant?

A Right. But he didn't do it prior to that date.

Q One he did in his office and another one he had her admitted to the hospital, didn't he?

A That is correct.

Q Then we come along a year later and he attempted another corneal transplant, did he not?

A Yes.

Q He had the pressure under control at that time?

A No.

Q The pressure was out of control at that time?

A It was out of control without medication.

Q But with medication --

A With medication, yes.

Q You are saying that what he should have done

was use a plastic lens in the eye?

A No.

Q You mean a plastic corneal replacement?

A No, I didn't say that he should have done it.

Q Are you saying, Doctor, that if this woman had been under your control, you could have prevented her from getting the condition she has today?

A I would have liked really to control the tension each time that I did a transplant, regardless of medication or no medication. But if it didn't come down, I would repeat the cyclocryotherapy or the cyclodiathermy, as I said before, as many as seven times.

Q You might have ended up, nonetheless, with eyes in the condition that Mrs. Johnson's are?

A Pardon me?

Q You might have ended up, notwithstanding your proposed therapy, with the same end result we have today, isn't that true?

A There is that possibility.

MR. BEGOS: Objection, your Honor.

THE COURT: Overruled.

Q Do you know Dr. Sears' position in Connecticut?

A I do.

Q Do you know the man personally?

A No, not personally, but I have seen him at meetings, yes.

Q He is chairman, is he not, of the Department of Ophthalmology?

A He has a very fine reputation.

Q Yale New Haven Hospital is a well known hospital, is it not?

A Yes.

Q Yale Medical School is one of the outstanding ones in the country, is it not?

A It certainly is.

Q In doing your review of the records here, did you take into consideration in giving your opinion what the pathology report showed about the cornea that was removed from Mrs. Johnson's eye?

A I read that, yes.

Q Why do doctors make up pathology reports like that?

A It is a routine thing, a routine procedure, in most hospitals.

Q Is that a standing good practice of physicians to take tissue that has been removed and subject it to examination?

A Definitely. Done routinely.

Q Is one of the reasons that tissue that is removed from the body is examined by an independent pathologist, because then there can be an independent evaluation about whether the surgery needed to be done in the first place?

A No.

Q Isn't that a reason why a pathologist checks the tissue?

A No.

Q Not at all?

A No.

Q You were asked to look at Dr. Pearlstone's records. Do you still have them in front of you?

A I think I gave them to the gentleman.

Q Actually, I don't think I need them. There was a drawing, was there not?

A Yes.

Q Did you find it helpful in giving your opinion that Dr. Pearlstone had made a drawing?

A Yes, it was helpful.

Q You have also examined Dr. Knapp's records, have you not?

A Yes.

Q He never made a drawing, did he?

A No.

Q He didn't put down where these posterior subcapsular plaques were, did he?

A As far as I know, no.

Q You haven't seen it, sir, if he made a drawing?

A No.

Q You don't know where in the eye other than the posterior these opacities were?

A What he said, I think, is sufficient, posterior subcapsular.

Q You are relying on what is in his records?

A Pardon me?

Q Are you relying upon what is in his records?

A On his record, yes.

Q Did you see any photos of what this opacity looked like in Mrs. Johnson's eyes?

A I didn't get that.

Q Can you take a photograph through the slit lamp of the lenses of a person?

A It is possible.

Q And that would show ehre a opacity was in within the lens, is it not?

A Yes, but it is not done as a routine procedure on every cataract of every patient.

Q You didn't see any photos of Mrs. Johnson's eyes?

A No.

Q Nor were these lenses submitted to pathological examination, were they, after they were --

MR. BEGOS: Objection.

MR. RHEINGOLD: I withdraw the question.

Q In looking over the hospital chart, the Columbia-Presbyterian records, of Mrs. Johnson for the two lens extractions, did you see any pathology reports of those two removed lenses?

MR. BEGOS: The basis for my objection, your Honor, is that this goes without the scope. If he asks him what the practice in the community was with respect to pathology examination of lenses, I would have no objection.

MR. RHEINGOLD: That would be his question, your Honor. I am asking if he saw it in the records.

THE COURT: I am going to sustain the objection. The record is in evidence.

MR. RHEINGOLD: No more questions, your Honor.

REDIRECT EXAMINATION

BY MR. BEGOS:

Q Doctor, marked striage following surgery, is that an indication of a departure from good and accepted practice?

A No.

Q Doctor, if marked striate or moderate striate or just simply striate disappears within a reasonable period of time following surgery, is that an indication that no serious trauma or injury to the cornea occurred at the time of surgery?

A Yes.

MR. BEGOS: No further questions.

MR. RHEINGOLD: No questions.

THE COURT: Thank you, Doctor.

(Witness excused.)

THE COURT: Do you have anything further?

MR. BEGOS: No, your Honor, I rest.

THE COURT: Do you have any rebuttal?

MR. RHEINGOLD: Yes, I have rebuttal testimony, your Honor.

Mrs. Johnson.

THE COURT: Will you bring Mrs. Johnson up, please?

Johnson vs Knapp 5/3 74 Civ 5437 rebuttal Mrs. Johnson

A N N A R. J O H N S O N, having been previously duly sworn, testified further as follows:

THE CLERK: You are still under oath, Mrs. Johnson.

DIRECT EXAMINATION

BY MR. RHEINGOLD:

Q Mrs. Johnson, you have been here throughout the whole trial, have you not?

A Yes.

Q Did you hear Dr. Knapp when he testified?

A Yes.

Q Did you demand surgery on both your eyes from Dr. Knapp?

MR. BEGOS: Objection to the form of that question, your Honor.

THE COURT: Sustained.

Q What did you tell Dr. Knapp about eye surgery on both your eyes?

A I don't know anything about eye surgery. I left it all up to Dr. Knapp.

Q What did Dr. Knapp say to you about eye surgery on both your eyes?

A That 95 per cent came out fine, and that I might

as well go ahead and have it done.

Q Did either of you discuss the question of convenience and doing them both at one occasion?

A No, sir.

Q Did Dr. Knapp say to you that he advised against doing both eyes at the same time?

A No, sir.

Q Did Dr. Knapp say to you that he was conservative?

A No, sir.

Q Did Dr. Knapp say he was only going to do both eyes at once because you were requesting it?

A No, sir.

Q Is that true?

A Pardon?

Q Your last answer is no?

A I am sorry, I am mixed up.

Q Did Dr. Knapp say to you, Mrs. Johnson, he was only going to do both eyes at the one hospitalization because you requested it?

A I never requested it.

Q Who suggested doing both eyes at the same hospitalization?

A Dr. Knapp said, "We might as well get it over with."

Q In addition to Dr. Knapp telling you that 95 per cent of the cases are successful, did he ever say to you you could go blind?

A I never knew you could go blind.

Q Did he ever say to you, Mrs. Johnson, you could go blind?

A No, he never said I could go blind.

Q Mrs. Johnson, would you have undergone cataract surgery if Dr. Knapp had said to you that you have vision in your eye which is satisfactory to you apparently, but you are going to have a cataract grow in due course of time, so why not have both eyes done at the same time?

MR. BEGOS: Objection.

THE COURT: Sustained.

Q Mrs. Johnson, after you had the cataract surgery, on the various occasions when you went back to see Dr. Knapp in his office, on any occasion, did you ever say to him in these exact words, that you had a frontal headache?

A No, sir, I don't know what it is.

Q Did you ever say to Dr. Knapp that you had a cold so you could not see out of your right eye?

A No. I may have said I had a cold, but not that I can't see.

Q On the last occasion that you saw Dr. Knapp

in the spring of 1973, did he tell you that he had another doctor set up to examine your eyes?

A No, he did not. He ushered us out of the office.

Q Did he say anything at that time about your future?

A No. He never said anything about our future. He said it was just one of those things, Mrs. Johnson.

Q Lastly, Mrs. Johnson, at the request of the defendants' office here, Mr. Begos' office, did you go to see a doctor at their request to examine your eyes?

A Yes. My husband and I came down to New York to see a doctor. I believe his name was Dr. Lisman.

Q Do you know about when that was?

A About a month ago, or so.

MR. RHEINGOLD: That is all the questions I have, your Honor.

CROSS EXAMINATION

BY MR. BEGOS:

Q Mrs. Johnson, you were aware before you saw Dr. Knapp that your sister, Mrs. Mezzanotte, had a cataract operation?

A Yes, I was.

Q Do you recall that that was sometime in 1963?

A I don't remember when, sir.

Q Do you recall whether or not your sister had any complications following that cataract extraction?

A I don't believe she did, sir.

Q Did there come a time, Mrs. Johnson, before you were operated on that your sister had another cataract operation in 1971?

A I don't know whether it was before or after my operation, sir.

Q Did your sister have any complications following that, that you know of?

A I didn't know of any complications.

Q Were you fairly close with your sister in the 1960s and early 1970s?

A No. My sister worked all the time, so I didn't get to see her. Only on holidays, sir. Special holidays.

Q Do you know whether or not your sister, following her cataract extractions, had laser therapy to her eyes?

A I don't know, but I don't believe so.

Q Mrs. Johnson, your mother had cataracts also, didn't she?

A She has a cataract, a traumatic cataract, from a horse hitting her when she was young.

Q Is that the extent of your knowledge with respect to your mother's cataracts?

A She has just one cataract, sir, from a horse hitting her.

MR. BEGOS: I have no further questions.

REDIRECT EXAMINATION

BY MR. RHEINGOLD:

Q Mrs. Johnson, at the occasions that you went to see Dr. Knapp before the surgery, did he ever ask you about your family histroy with regard to whether other people in it had cataracts?

A No, sir, he did not.

MR. RHEINGOLD: That is all.

THE COURT: Thank you.

(Witness excused.)

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5/3 charge

lhrf 1

(In open court, jury present.)

Judge W. C. Conner

THE COURT: Before I begin my charge, I would like to comment very briefly upon the summation of Mr. Rheingold with respect to just two matters. He referred at one point to the possibility that the operation might have been performed on one or both of Mrs. Johnson's eyes not by Dr. Knapp but by the resident who was assisting in the operation. There is no evidence which indicates that the operation was performed by anyone other than Dr. Knapp, and, as I recall, Dr. Knapp testified that he performed the operation himself. So disregard that suggestion that the operation may have been performed by the resident.

The other matter is that in his summation Mr. Rheingold commented upon the fact that a specimen or more specifically the removed lens was not sent for pathological examination. There is no evidence that as of 1972 it was customary or expected that a lens with a cataract which had been removed would or should be sent for pathological examination. So don't draw any unfavorable inference from the fact that the lenses that were removed were not sent for examination for pathology. Now to the charge itself.

You are about to begin your final function as jurors in this case, and that is to decide the facts of the case. As I told you at the outset, as members of the jury you are the sole and exclusive judges of the facts. You and you alone determine the weight of the evidence and you determine the credibility of the witnesses and the reasonable inferences, if any, to be drawn from the evidence or lack of evidence in the case.

In your determination of the facts, you rely only upon your recollection of the evidence. What I may have said from time to time during the trial or what I say now in these instructions is not evidence in the case. Likewise, what the attorneys said in their opening statements and what they said in their closing arguments or summation is not evidence in the case. The only evidence on which you should base your verdict is the testimony of the witnesses from the stand, the exhibits that were introduced into evidence, the portions of depositions, that is out of court testimony, which were read and the answers to written interrogatories, that is written questions, which were read.

Likewise, no comments that were made by counsel or by the Court, either in making objections or in ruling upon objections, should have any influence upon you in

reaching your verdict. Don't try to speculate what my thinking about the merits of the case might be on the basis of any ruling that I made during the course of the trial or anything I may have said in the course of such rulings. These are matters of law which need not concern you at all in your determination of the facts.

Also, please don't be concerned by the fact that I may have asked questions of the witnesses at various points during the trial. Whenever I asked a question, I did so only because I thought something was left unclear and I wanted it to be clarified insofar as possible so that you wouldn't be confused about the matter in your determination of the facts. If I sustained an objection to a question after the witness had answered or partially answered the question, or if I told you at any point to disregard a statement by counsel or testimony by a witness, you must disregard that answer or that statement and put it completely out of your mind in your determination of the facts.

As jurors, you should perform your duties logically and dispassionately and without emotion. You should not allow sympathy for one side or prejudice against the other side to influence your decision in any way.

Your verdict should be based only upon the evidence in the case or the lack of evidence. It should not be based upon speculation or conjecture, although as I indicated a moment ago, you are permitted to draw reasonable inferences from the evidence or the lack of evidence. You should consider both direct evidence and circumstantial evidence.

Direct evidence is evidence which comes from a witness who saw or heard or felt a thing. In other words, it is information that he acquired directly, through his own senses.

Circumstantial evidence, on the other hand, is evidence of one fact which bears such a logical relation to a fact in issue, that it tends to prove the existence of the latter fact.

The law makes no distinction between the weight to be given direct evidence and that to be given circumstantial evidence. Both should be considered by you in determining your verdict. As I indicated, you will be called upon to determine the credibility, that is the believability, of the witnesses and the weight to be given their testimony.

In determining the credibility or believability of a witness, you should consider a number of factors, including whether the person who was testifying was in

a position to have personal knowledge of the facts about which he testified, whether or not his story was plausible, that is whether it made sense to you, whether or not his testimony was corroborated or reinforced by other evidence in the case, or whether it was contradicted by other evidence.

You should also consider whether the witness has an interest in the outcome of the case. In other words, whether he had an incentive or motivation to falsify or exaggerate or to slant his testimony in any respect.

You should also consider the demeanor of the witnesses, that is their behavior, on the stand. Did they appear frank and forthright, or were they evasive and shifty.

To sum up, in determining whether a witness is worthy of your belief, you use your common sense, just as you would in evaluating statements made to you by persons in your every day life or business life. To use a colloquial expression, you size the man up, or the woman, as the case may be, and you determine the extent to which their statements to you seem worthy of your belief just as you would in determining the believability of persons in your own affairs.

If you find that the testimony of a witness has been disproven and that he knowingly testified

incorrectly about a particular fact, then it will be up to you to decide what weight to give the remainder of his testimony. You may decide that because he testified falsely about one fact you should not believe anything that he said.

On the other hand, you may decide that notwithstanding the fact that he testified incorrectly about one matter, you should give full faith and credit to all of the rest of his testimony.

The rules of evidence ordinarily do not permit a witness to testify as to his opinion or his conclusion. But one exception to this rule is the testimony of expert witnesses, such as medical doctors. However, the wight to be given the testimony of a medical doctor, like the weight to be given the testimony of any witness, is up to you, the jury, to decide, and you go about deciding what weight to give the testimony of an expert witness in exactly the same way you would determine the credibility of any other witness. That is, you consider the plausibility of their testimony, whether they were in a position to know of their own knowledge the facts about which they testified, whether they had an interest in the case, whether they were frank and forthright or evasive, and so on.

To have evidentiary weight, the opinion of an expert witness must be based upon proven facts. From time to time during the trial, the expert witnesses may have been asked what we call hypothetical questions. A hypothetical question is simply a question that assumes a certain state of facts and then asks the expert witness his opinion based upon that assumed state of facts.

Obviously, in order for that opinion to have any weight at all, the facts which were assumed must have been established. If you find that some of the facts which were assumed in posing the question to the witness were not established by the evidence, then, of course, you must disregard the witness' testimony as to his opinion or conclusion, based upon the set of facts which was not proven.

In this, as in every case, the plaintiffs having brought the suit have the burden of proof of establishing all of the essential elements of their case. This means that they must prove each of these elements by a fair preponderance of the credible evidence. Proof by a fair preponderance of the credible evidence means that considering all of the evidence in the case, you are more inclined to believe the facts in issue than you are inclined to disbelieve them.

If the evidence is equally balanced between evidence tending to prove a particular fact and evidence tending to disprove it, then you must find, with respect to that fact, against the party who has the burden of proof as to that fact, because that person or that party will have failed to carry his or her burden of establishing the necessary element of its case by a fair preponderance of the credible evidence.

The preponderance simply means the greater weight of the evidence, considering not the quantity of the evidence, that is not the number of witnesses or the length of their testimony, but the quality of the evidence, that is the believability of the witnesses, and the weight of the evidence on one side as compared to the evidence on the other.

The expression fair preponderance of the credible evidence does not mean that the plaintiff has the burden of proving the essential ingredients of her case beyond a reasonable doubt, which is the standard that is often applied in criminal cases. It is only necessary that the party with the burden of proof establish its case by a fair preponderance of the credible evidence; in other words, by the greater weight, the greater quality, of the evidence.

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Now let's turn to the particular allegations and the necessary ingredients of the plaintiffs' case here. The plaintiffs claim in this case is based upon alleged malpractice by the defendant, Dr. Knapp, in connection with the cataract removal operations performed on the eyes of the plaintiff, Mrs. Johnson, in October and November, 1972. Malpractice is simply negligence on the part of a physician. Negligence is lack of ordinary care. Negligence may consist of either doing something which a reasonably prudent person would not do under the same or similar circumstances, or failing to do that which a reasonably prudent person would do under such circumstances, in order to avoid injury to himself and others about him.

Where we have a physician charged with malpractice, the standard of ordinary care is not the standard that would be applied to a layman, but the standard is that of an ordinary physician.

In this case, we have a specialist, an ophthalmologist, so we have an even more refined standard of care that must be met in this case.

The defendant, Dr. Knapp, was under a duty to use the care and skill which an ordinary ophthalmologist operating in the New York Metropolitan area in the fall

of 1972 would have used. That will be the critical determination that you must make in this case.

Medical practitioners in general, and ophthalmologists in particular, do not insure their patients against harm and they do not guarantee a favorable result with every operation. They are only required to exercise ordinary care and skill under the circumstances, that is the skill and diligence of the ordinary ophthalmologist engaged in practice at that time and place.

You may not infer or conclude from the mere fact that a bad result occurred that it occurred because of the negligence or malpractice of Dr. Knapp in his surgical care and treatment of the patient. The plaintiff is not entitled to a verdict and cannot recover any damages against Dr. Knapp unless she meets her burden of establishing by a fair preponderance of the credible evidence two essential elements:

1, that Dr. Knapp departed from the methods of care and treatment generally employed by ophthalmologists under the same or similar conditions and circumstances, and 2, that such departure was a competent producing cause of Mrs. Johnsons' condition.

If the plaintiff fails to meet her burden of proof as to both elements, even though you may find

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that she has met her burden of proof as to one element, then your verdict must be for Dr. Knapp.

A physician who renders medical service is obligated to have that reasonable degree of knowledge and ability that is expected of like specialists who do the sort of examination, treatment and operation involved. The law recognizes that there are differences in the abilities of doctors, just as there are in the abilities of people engaged in all other activities.

To practice his profession, a doctor is not required to be possessed of extraordinary knowledge and ability that belong to few men of rare endowments, but he is required to keep abreast of the times and to practice in accordance with the approved methods and means of treatment in general use.

The standard to which he is held is measured by the degree of knowledge and ability of the average ophthalmologist at the time and place in question. In performing a medical service, the doctor is obligated to use his best judgment and to use reasonable care in the exercise of his knowledge and ability.

The rule requiring him to use his best judgment does not make him liable for a mere error of judgment, provided he does what he thinks best after careful

examination. The rule of reasonable care does not require the exercise of the highest possible degree of care. It only requires that he exercise that degree of care that a reasonably prudent ophthalmologist would have exercised under the same circumstances.

If a patient should sustain an injury while undergoing medical care, and that injury results from the doctor's lack of knowledge or ability or from his failure to exercise reasonable care or to use his best judgment, then he is responsible for the injuries that result from his acts.

However, if you find from the evidence that it is just as likely that Dr. Knapp did not depart from proper ophthalmological practice as that he did, then your verdict must be for Dr. Knapp, for the plaintiff will have failed to sustain her burden of proof on the issue of negligence or malpractice.

Moreover, if you find from the evidence that there was a departure by Dr. Knapp from the methods generally employed by ophthalmologists under the same or similar circumstances, but you also find that it is just as likely that such departure did not cause or aggravate the cystoid macular edema or cause or aggravate the trauma or the damage to the cornea which later resulted,

as that it did cause or aggravate one of those conditions, your verdict must be for Dr. Knapp.

However, I want to emphasize that in giving you this instruction, I am not suggesting either that there was or that there was not a departure by Dr. Coleman from accepted medical standards. Where several operative procedures are available to a physician, any one of which is medically acceptable and proper under the circumstances, a physician cannot be held liable for malpractice when he uses one of the several acceptable techniques.

One of the ways in which Dr. Knapp is alleged to have departed from acceptable medical standards was in failing to inform Mrs. Johnson about the hazards involved in the removal of a lens, particularly where both lenses are being removed in a single hospital admission.

A physician is under a duty to divulge to his patient the risks which singly or in combination, tested by general conditions of reasonable disclosure under all the circumstances, will materially affect the patient's decision whether to proceed with the proposed treatment.

The patient may always choose between apparent dangers, one attendant upon the surgery, the other resulting from the continuation of an existing condition

because of the decision not to undergo surgery.

However, there is no obligation on the part of a physician to enumerate each and every contingency that may arise during an operation. If you find that Dr. Knapp disclosed the facts and risks which a reasonable ophthalmologist would have disclosed under similar circumstances, then you must return a verdict in favor of Dr. Knapp on this issue.

If,on the other hand, you find that Dr. Knapp failed to disclose what a reasonable ophthalmologist should have disclosed under the circumstances in order to permit Mrs. Johnson to make an informed choice whether or not to undergo the operation on both eyes during the single hospital admission, then you must return a verdict in favor of the plaintiffs on this issue.

I am going to talk briefly about the method of computation of damages. However, I want to emphasize that in talking about the subject of damages, I do not want you to assume that I have any feeling that you should or will conclude that Dr. Knapp has been guilty of any malpractice. I have to talk about the subject of damages so that in the event you find that the doctor has been guilty of malpractice, you will know how to go about computing the amount of damages which should be

awarded to Mrs. Johnson and her husband. There are four elements of damages which you should take into consideration. Two of them apply to Mrs. Johnson and two of them apply to her husband.

First, the two that apply to Mrs. Johnson are the loss of bodily function, in this case eyesight, and the resulting restriction in her activity.

The second is pain and suffering.

The two that apply to Mr. Johnson are, first, the medical and hospital expenses, and, secondly, the loss of the companionship and services of Mrs. Johnson.

I want to emphasize again that with respect to each of these four elements of damages, the plaintiffs have the burden of proof, and they must show you what the damages were and they must further show you that these damages were the result of or were caused by the malpractice or negligence of Dr. Knapp. It isn't enough that there was an expense or that there was a deprivation in order for you to assess the damages against Dr. Knapp. You must find that the expense or deprivation or other element of damages was a result of the malpractice or negligence which you have found, if you find such. If you don't, of course, you will never even get to the matter of computing damages.

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Let's talk first about the loss of eyesight and the resulting restriction in activities. There is no way that I can tell you how to compute this. You will have to use your own common sense and your own experience, and your objective will be to determine what amount of money will fairly compensate Mrs. Johnson for this loss of her abilities and the resulting restriction in her activities.

You have had some testimony concerning what her activities were before her eyesight started to fail and up to the time of the operation. There is conflicting evidence as to what she could do up to the time of the operation, and you will have to decide on the basis of that conflict what she could actually do. You will have to also decide what would have been her condition even if there had not been an operation, and you will have to determine the extent to which her condition was worsened and her activities restricted as a result of the operation, if you find that there was negligence or malpractice.

With respect to pain and suffering, likewise, you will have to determine what amount of money will fairly compensate Mrs. Johnson for the conscious pain and physical suffering and anguish that she suffered as a result of any negligence or malpractice on the part

of Dr. Knapp.

The testimony about the medical and hospital expenses is fairly clear, and if there is negligence or malpractice, I don't think there will be any problem in your determination of the medical and hospital expenses, with the exception, that you must find that whatever expenses you award as an element of damages were reasonable and necessary.

The final element is the loss by Mr. Johnson of Mrs. Johnson's companionship and services. You will have to figure what amount of money will fairly compensate him for the fact that he has lost her companionship and that certain services she was performing for him and for the household are no longer being performed by her.

With respect to the loss in her activities and the loss of services, you will have to take into consideration not only the past loss of activities and services, but also the future loss of activities and services. In that connection, according to the statistical tables of life expectancy, at the present time Mrs. Johnson, who is now 43 years of age, has an average life expectancy of 35 years. I want to emphasize, that doesn't mean that she will actually live that long. She may live much longer, she may live much less.

That is only a statistical average for a woman of her age, and you will have to determine from the testimony and the other evidence in the case about her present state of health and her personal habits and all the other facts and circumstances known to you what her actual life expectancy is under the circumstances.

To aid you in reaching your verdict, I have made up a list of three questions, which will be answered by you. I will read them.

Question 1: Did Dr. Knapp fail to use the skill and care of an ordinary ophthalmologist at the time and place in question?

Answer yes or no in the balnk. If the answer to question 1 is no, no further questions need be answered, because you will have found that he didn't fail to use ordinary care, that he wasn't guilty, in other words, of any negligence or malpractice, and your verdict will therefore be in favor of the defendant, Dr. Knapp.

Question 2 reads, if the answer to question 1 is yes, was such a lack of skill and care a competent producing cause of Mrs. Johnson's blindness?

Answer yes or no in the blank. I use the term blindness there not in the technical sense, because, as you fully realize, she has some sight in her left eye.

I use it only to shorten the question. You will have to determine whether or not her present condition is a result of any lack of skill or care on the part of Dr. Knapp or whether it was caused by something else.

If the answer to question 2 is no, no further questions need be answered, because, again, if you answer that question no, you will have decided that whether or not Dr. Knapp was negligent or guilty of malpractice, Mrs. Johnson's present condition is not a result of that lack of skill or care on his part.

Question 3: If the answer to both question 1 and question 2 is yes, what amount of damages will fairly compensate Mrs. Johnson and her husband for the injury or less they have suffered?

Then there are two blanks, one for Mrs. Johnson with a dollar sign to be filled in, and one for Mr. Johnson, likewise followed by a dollar sign and a blank. In the case of Mrs. Johnson, you will consider the two elements that I indicated before, that is the loss of her bodily function and the resulting restriction in her activities, and, secondly, the pain and suffering. With respect to Mr. Johnson, you will consider the hospital and medical expenses and the loss of her companionship and services.

Then at the end there is a place for signature by the jury foreman. Juror No. 1, Mr. Block being the first juror chosen, would normally be the foreman of the jury. However, if he would prefer not to have that job, he may simply say so and you may select another of your group to preside over your deliberations and to sign the questionnaire and report the verdict.

When you go to the jury room to begin your deliberations, I am sure you will find that you begin with many differing points of view, perhaps as many different points of view as there are deliberating jurors. The purpose of your deliberation is for each of you to participate and to freely express your various points of view and to keep an open mind and listen thoughtfully and receptively to the points of view of your fellow jurors.

Just because you express a point of view at the outset, please don't feel that you have got to stubbornly defend that position or to justify it. Keep an open mind and listen to what your fellow jurors are saying and ask yourself whether or not you cannot conscientiously adopt some or all of their points of view as your own.

Obviously, the purpose of your deliberation is

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to try to reach a single verdict which represents the conscientious point of view of all of you. So be flexible and be receptive. Don't be stubborn or antagonistic. Don't feel that you have got to win the argument or that you have got to convince all of your fellow jurors to come around to your point of view. Try to meet at one common ground which will ultimately represent the true opinion of each and every one of you. That isn't to say that if after hearing and carefully considering all of the other points of view you must give in simply because you are outnumbered. The final verdict must represent the conscientious view of all six of the deliberating jurors.

The verdict, in other words, must be unanimous, if that is possible. You may find, as you proceed in your deliberations that you will have difficulty in remembering some of the testimony or some of the other evidence in the case, or even that you have differing recollections of the evidence.

If you want to hear any of the testimony again, all you have to do is to send a note out to me through the marshal who will be posted at the door of the jury room, and we can have the court reporter read from his notes the relevant portion of the testimony.

Likewise, if you want to have any of the exhibits available in the jury room for your inspection, just send out a note and we will be glad to send any or all of the exhibits in to you.

Likewise, if you can't remember something I said in the charge, or if I fail to make anything clear, please let me know, and I will be glad to explain or to supplement the charge. I will see counsel in the robing room.

(In the robing room.)

MR. RHEINGOLD: No exceptions or requests on the part of the plaintiff, your Honor.

MR. BEGOS: The only exception I have, your Honor, I am sorry I have to make it, is that an exception that a physician is under a duty to expose to his client the risks which if singly --

THE COURT: I noted that when I read it. I think I should clarify that. I think that is a little misleading in that it sounds as thought he has to specify the risks in some detail, and I think that is an unfortunate suggestion. I will clarify that.

MR. RHEINGOLD: That, your Honor, is a verbatim quote from the New York Law.

THE COURT: That may be, but I think that it has an unfortunate suggestion in the light of the evidence

in this particular case. I will clarify that. I think I will do it in a way that you won't find objectionable. Anything else?

MR. BEGOS: As far as requests, again I would renew my request for specific findings that we discussed, and your Honor indicated you were not going to give. I just wanted to reserve my right to that request.

THE COURT: All right.

(In open court.)

THE COURT: I want to clarify my charge in just one respect. I said that a physician is under a duty to divulge to his patient the risks which singly or in combination will materially affect the patient's decision whether to proceed with the proposed operation.

I think there is an unfortunate suggestion there. I do not mean to suggest that the doctor ought to go into detail and to specify all of the horrible things that might happen as a result of an operation. I think a physician is under a duty to inform the patient about the risks to the extent that the patient can exercise an informed judgment. This does not mean, however, that each of the contingencies must be discussed individually or in detail. You will have to determine what a reasonable ophthalmological surgeon would have disclosed to a patient,

such as Mrs. Johnson, under comparable conditions.

In that respect, you should consider the particular patient involved and what the evidence has shown about Mrs. Johnson and her psychological makeup.

Anything further?

MR. RHEINGOLD: No, your Honor.

(Two alternate jurors were excused.)

(One marshal was duly sworn.)

THE COURT: I should tell you one further thing, lest you be concerned about being kept late. My normal practice is not to keep juries very late, because, as we all know, it isn't safe to go about the streets of New York late at night, and I am sure you would all like to be with your families or friends at a decent hour tonight.

We will operate until about 6:00 o'clock. If you can reach a verdict before then, fine and good. If you do not, we will excuse you then and you can go your separate ways and come back to the jury room at 10:00 o'clock in the morning and resume your deliberations.

(Jury commenced deliberations at 4:47 p.m.)

(Jury not present.)

THE COURT: May we stipulate that if the jury requests any of the exhibits, that you will be notified

and the exhibits will be automatically sent in, without the necessity of my being sent back down here for that purpose.

MR. BEGOS: Yes. Perhaps we can work the exhibits out right now.

MR. RHEINGOLD: There are sections that shouldn't go to the jury.

THE COURT: You better redact them.

(Recess.)

(6:05 p.m., in open court, jury present.)

THE COURT: As promised, I am going to let you go now. You can come back at 10:00 o'clock in the morning and resume your deliberations. In the meantime, don't discuss your case with anybody. Your deliberations are to take place only with all of you present, so that everyone is fully aware of everything that is said and everything that is done in connection with your deliberations.

Have a good evening.

(Adjourned.)

Anna R. Johnson and Robert K. Johnson

vs 74 Civ. 5437

Phillip Knapp and D. Jackson Coleman

New York, New York
May 4, 1976

(Trial resumed.)

(In open court, jury not present.)

(Court's Exhibit 1 marked for identification.)

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THE COURT: For the record, there is a note from the jury which was received about two hours ago, at 10:15 this morning, and it contains three numbered items:

No. 1 reads, "Dr. Knapp's office records."

I understand with respect to that that the office records have been furnished to the jury.

MR. RHEINGOLD: Yes, your Honor.

THE COURT: Immediately after their request. Item 2 reads, "Dr. Knapp's testimony on how much information he gave Anna Johnson on the last visit before the operation."

I understand in respect to that that counsel have gone over the transcript of Dr. Knapp's testimony in an attempt to agree on the portions to be read to the

jury in response to that request, and that there is some lack of agreement.

MR. RHEINGOLD: That is correct, your Honor. The only disagreement is whether the cross should be read. We have identified the sections in the direct and cross that deal with their request. I feel that they didn't say they wanted the direct, they wanted the testimony, and that my cross examination should be read as well as the direct.

THE COURT: I would think by all means that both cross and direct should be read, because they have asked for the testimony without limitation.

MR. BEGOS: Then if that be the case, we know exactly what has been read by way of cross and the direct. There is no disagreement as to what will be read on direct. We can agree, then.

MR. RHEINGOLD: Can I state it for the record, your Honor, the pages that we have agreed to?

THE COURT: You may.

MR. RHEINGOLD: On direct, page 38, line 1 to page 39, line 14.

MR. BEGOS: That is two. From 38-1 to 39-14.

MR. RHEINGOLD: Yes. On cross examination, from page 96, line 9, to page 106, line 2 and from page 124,

line --

MR. BEGOS: No, I disagree to line 24. We discussed that inside. I thought we agreed that page 124 was --

MR. RHEINGOLD: Just one moment.

(Pause.)

MR. BEGOS: Your Honor, page 124, line 24 is "How many had you done bi-laterally both eyes before you did Mrs. Johnson?

"A I did one.

"Q Did you tell that to Mrs. Johnson?

"A I don't think I specified."

Then there was an objection, overruled. The question can be answered.

"A No."

I don't specifically think that that refers to that conversation or the contents of what --

THE COURT: Was this at the last visit before the operation?

MR. BEGOS: It does not -- it would seem in the context possibly that it might have been.

THE COURT: I think it probably should be included because the request is not limited. It says Dr. Knapp's testimony on how much information he

gave Anna Johnson the last visit before the operation. It would seem to me that that is testimony as to how much information was given to Mrs. Johnson at that time.

MR. RHEINGOLD: That would be, then, your Honor, from page 124, line 24, through page 128, line 21.

MR. BEGOS: I believe on page 130 there is also -- that relates to the sister.

THE COURT: Anything else?

MR. BEGOS: Yes, page 130:

"Are you relying on your record as to whether or not you were told that? In other words, from the absence of what is in your records, you say you were not told about her sister?"

"I certainly would have thought it would have been typed in."

That would again relate and refer to that same area.

MR. RHEINGOLD: No objection, your Honor.

MR. BEGOS: The next question, "Did Mrs. Johnson tell you that she had a sister with cataract extractions nine years apart?"

"I don't think I was here when I heard when when that was brought out. "

"Assuming that is true, I can't ask it that way,

read that, or if you would like for me to paraphrase it on an ad lib basis, I can do that.

MR. RHEINGOLD: I think it would be safer to have the reporter reread it, your Honor. I am concerned that if, for example, we heard it now, it might not make much sense without having the charge to which it was an appendage read.

THE COURT: But they have only asked for the last charge. I think as a matter of fact that that last explanation is a fairly good summation of what the law is anyway, that they should determine what a reasonable ophthalmological surgeon should have told Mrs. Johnson under the circumstances and determine whether or not he met that standard.

MR. RHEINGOLD: All right.

THE COURT: I think that is in essence what the last explanation was.

MR. BEGOS: The only problem I have about that, I think that may be their hangup, is that between that first charge in that area and the reexplanation, which was good but poses the same difficulty, the implication may arise that what you are telling them is that the law is that he must not only explain, but that he must give some risks.

you have no recollection of having been told that?"

"No."

THE COURT: Actually, if counsel agree, I am agreeable, but that isn't technically within the request because the request relates to Dr. Knapp's testimony on how much information he gave Anna Johnson, not how much information Anna Johnson gave him.

MR. BEGOS: There is also in the cross examination, if we were to be that hypertechnical, some of the cross examination relates to some of the areas that she explained or what information she gave.

THE COURT: If counsel are agreeable, I have no objection.

MR. RHEINGOLD: I agree to that.

THE COURT: Item 3 reads, "Judge's last charge over what is expected of a physician on informing a patient before an operation (where Judge Conner reiterates at the very end of charge.)"

The fact that the request refers to the last charge and the fact that it is further explained by a reference to the reiteration at the very end of the charge, I assume, relates to the explanation that I gave after I came out of the robing room conference.

If you like, we can merely have the reporter

THE COURT: The purpose of the explanation was clear. In that I specifically said he did not have to specify any risks necessarily.

(Record read.)

MR. BEGOS: Again you do seem in the mid-portion of that instruction to say that it is the law that some risks must be explained to the patient.

THE COURT: I say they don't have to be catalogued individually or individual in detail. If you prefer or if counsel agree, I can attempt to paraphrase it again. Since there was no exception to the charge at the time it was given and since they have requested it again, if there is an objection by either side, I will merely have this reread.

MR. RHEINGOLD: I would object, your Honor, and prefer that it be reread.

THE COURT: All right, I will have it reread. I think it might be fair to supplement it a little bit and simply say that I do not mean to suggest that even one of the contingencies has to be specifically named or discussed, that they will have to determine what a reasonable surgeon would do under the circumstances.

MR. BEGOS: I would be satisfied with that. Otherwise I realize how difficult it is to phrase

under the present state of the law an acceptable charge on informed consent.

(Jury present.)

THE COURT: I want to apologize to you for keeping you waiting for so long. I had started a criminal trial this morning and we were in the process of selecting the jury, and the selection process in a criminal trial takes a much longer time because we have 12 jurors and four alternates, and there are three defendants, all of whom have to participate in the selection process.

It takes a long time and I couldn't interrupt it because we had 80 prospective jurors waiting.

In addition, counsel had to go over the transcript to agree on the parts that would be read to you in response to your request for a rereading of the part of Dr. Knapp's testimony relating to the information that he gave Mrs. Johnson at the time of their last meeting before the operation.

We will comply with that request now, and the reporter will read to you the part of the testimony that the parties, with the participation of the Court, have agreed upon.

(Record read.)

THE COURT: The last item in your note is a

request for the Judge's last charge on what is expected of a physician with respect to informing a patient before an operation, and you specifically refer there to my reiteration at the very end of the charge.

The reporter will read to you what I said at that time and then I may add a few words of clarification.

(Record read.)

THE COURT: I want to clarify that further, to this extent. I do not mean to suggest that the doctor has got to discuss any specific contingency or possible adverse outcome. You will have to determine what a reasonable ophthalmological surgeon should have disclosed to a partient of the physical and emotional and psychological makeup of Mrs. Johnson, under all of the circumstances that obtain here. You will have to decide whether he did what a reasonable ophthalmologist would have done under the circumstances or whether he failed to do so, and you will understand, of course, that with respect to this issue, the plaintiff has the burden of proving that he failed to measure up to the standards of a reasonable ophthalmologist under those conditions.

Is there any further question or is that clear? It is now a quarter of 1:00, so you can go directly to

lunch.

I understand that the marshal is going to take you out. Have a good lunch.

(Luncheon recess.)

(4:30 p.m., in open court, jury not present.)

THE COURT: Gentlemen, I have a note from the jury foreman, Mr. Block, which we will mark as Court's Exhibit 2, and it reads:

"Judge Conner, we have reached a verdict but we would like to know if it would be permissible to make a short statement."

Signed "Richard L. Block."

Have you any comments about the permitting the short statement?

MR. RHEINGOLD: No objection, your Honor.

MR. BEGOS: I guess I can't.

THE COURT: I will permit it. Bring the jury in, please.

(Jury present.)

(Court Exhibit 2 marked for identification.)

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THE CLERK: Members of the jury, please answer present as your name is called.

(All jurors present.)

THE CLERK: Mr. Foreman, has the jury agreed upon a verdict?

JUROR NO. 1: Yes, we have.

THE CLERK: Question No. 1, did Dr. Knapp fail

to use the skill and care of an ordinary ophthalmologist at the time and place in question?

Your answer,please?

JUROR NO. 1: No.

THE CLERK: Was such a lack of skill and care a competent producing cause --

THE COURT: No, no.

JUROR NO. 1: There is no other answer.

THE COURT: I understand from the note that you sent out that you wish to make a brief statement. Neither counsel objects to that, and the Court will permit you to do so.

JUROR NO. 1: Right. Even though we found Dr. Knapp not guilty of malpractice as set down in the questions directed to the jury by the Judge, considering all the defense, we feel that according to the given testimony Dr. Knapp failed to establish a sound patient-doctor relationship. That is the extent of the statement.

THE COURT: Thank you very much. I want to congratulate each of you and to thank you very much on the way in which you conducted yourself throughout the trial. You obviously paid attention to the evidence as it went in, and you obviously gave care and thought to your deliberations. I know that it isn't a pleasant thing to give up your own private affairs and

to come and spend the time here sitting in judgment on the affairs of others, but having now had this exposure to the way our system of justice works, I hope you have a little better appreciation about the importance of your function, and you realize that the sysgem just couldn't work without people such as yourselves who are willing to give up your own affairs for a brief time to perform this very important function. We are all very much in your debt, and I thank you very much.

The jury is discharged.

MR. BEGOS: May I on behalf of myself and Dr. Knapp thank each and every one of them.

(Jury excused.)

(Concluded.)

6.25

6.25

United States Court of Appeals
for the Second Circuit

ANNA R. JOHNSON & ROBERT K. JOHNSON, PLAINTIFFS
- AGAINST -
PHILLIP KNAPP & D. JACKSON COLEMAN, DEFENDANTS

United States Court
Southern District of
New York

Case No. 74-5437civil4

Judge CONNER

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6 21 6 21

CIVIL DOCKET

NITED STATES DISTRICT COURT

JUDGE C[illegible]

Jury demand date:

by pltff 12-12-74

Form No. 106 Rev.

TITLE OF CASE	ATTORNEYS
ANNA R. JOHNSON AND ROBERT K. JOHNSON VS. PHILLIP KNAPP, AND D. JACKSON COLEMAN,	For plaintiff: PAUL D. RHEINGOLD 200 PARK AVENUE, N.Y.C. 10017 661-0055 5/74 For defendant: ANTHONY L. SCHIAVETTI 1633 Broadway-NYC 10019 (489-7500) (for defts.)

628

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STATISTICAL RECORD	COSTS		DATE	NAME OR RECEIPT NO.	REC.	DISB.
J.S. 5 mailed X	Clerk		6/4/74	Record on file	15 —	15 —
J.S. 6 mailed ✓	Marshal					
Basis of Action: PER INJ. NEG.	Docket fee					
	Witness fees					
Action arose at:	Depositions					

UNITED STATES COURT OF APPEALS
FILED
JUN 1 1974
SECOND CIRCUIT

A

627 627

ANNA R. JOHNSON ET-ANO VS. PHILLIP KNAPP AND D. JACKSON COLEMAN.

74 Civ. 840

DATE	PROCEEDINGS	Date Orde Judgment I
12-74	Filed Complaint, Issued Summons.	
22-75	Filed summons and return-served the followingt	
	D. Jackson Coleman by Janet Letscher on 1-17-75	
	Dr. Phillip Knapp by Mrs. Daley on 12-30-74	
. 24-75	Filed stip & order extending deft. D. Jackson Coleman's time to answer to 2-25-75. So ordered- CONNER, J.	
. 28-75	Filed ANSWER of deft. Phillip Knapp to the complaint	A.L.S.
. 28-75	Filed ANSWER of deft. D. Jackson Coleman to the complaint	A.L.S.
. 28-75	Filed deft. Phillip Knapp's interrogs.	
. 28-75	Filed deft. D. Jackson Coleman's interrogs.	
. 28-75	Filed pltffs' cross notice of taking depositions of defts. on 5-13-75	
5-75	Filed pltffs' interrogs. to deft. D. Jackson Coleman	
5-75	Filed pltffs' interrogs. to deft. Phillip Knapp.	
7-75	Filed defts' notice re: request for hospital records.	
.14-75	Filed pltff's answers to interrogs. demanded by deft. P.Knapp.	
.14-75	Filed pltff's answers to interrogs.,demanded by deft. J.Coleman.	
y 23-75	Filed deft. Phillip Knapp's answers to interrogs.	
g. 6-75	Filed deft. Donald Jackson Coleman's answers to interrogs.	
.19-75	Filed pltff's affdvt.& notice of motion compeling answers to sets of interrogatories served upon the deft's and for award of costs....Ret.8-19-75.	
.9-75	Filed memo endorsed on motion filed 8-19-75....Motion granted in part at oral	

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	hearing 9-5-75...So. ordered Conner,J....
-5-75	PRE-TRIAL CONFERENCE HELD BY CONNER J.
. 1-75	Filed deft. Donald Jackson Coleman's supplemntary answers to interrogs.
t. 3-75	Filed deft. Phillip Knapp's supplemntary answers to interrogs.
2-13-76	Filed pltffs' notice of taking deposition of Dr. Marvin Sears on 03-01-76
2-18-76	Filed stip & order that the defts' answers are amended to include as indicated. So ordered- CONNER, J.
-09-76	Filed pltffs' notice of taking deposition of Dr. Marvin Sears on 3-29-76
-12-76	PRE-TRIAL CONFERENCE HELD BY CONNER, J.
03-24-76	Filed defts' affdvt. and notice of motion for an order establishing a Medical Malpractice Panel. Ret. 04-02-76
-24-76	Filed defts' memorandum of law in sopport of motion.
-30-76	Filed pltff's affdvt. of Paul D. Rheingold in opposition to motion for the appointment of a medical malpractice panel .
03-30-76	Filed pltff's brief.
4-06-76	Filed Memorandum and Order-Opinion #44179-- for the reasons stated, defts' application for a pre-trial convention of a Medical Malpractice Panel pursuant to the provisions of N.Y. Judiciary Law Section 148-a, must be denied. So ordered- CONNER, J. (m/n)
4-20-76	Filed pltffs' requests to charge. (W. C.
04-26-76	BEFORE CONNER, J. Jury trial begun.
04-27-76	trial con'td
4-28-76	trial cont'd. Deft. motion to dismiss complaint as to deft. Jackson Coleman-granted.
4-29-76	trial cont'd
05-03-76	trial cont'd
5-04-75	trial cont'd and concluded. Jury verdict for deft.
05-07-76	Filed Judgment- that deft. Dr. Phillip Knapp have judgment against pltffs. dismissing the complaint- and that the complaint is dismissed as to deft. Dr. Jackson Coleman. Clerk, Approved- CONNER, J. (m/n)
-20-76	Filed pltffs' notice of appeal to USCA from the judgment entered on 5-4-76.
	Copies mailed to: Paul Rheingold and Anthony L. Schiavetti. Ent. 5-27-76

A TRUE COPY
RAYMOND F. BURCHARDT, Clerk
By _____ Deputy Clerk

631 631

SOUTHERN DISTRICT OF NEW YORK

ANNA R. JOHNSON AND ROBERT K. JOHNSON, PLAINTIFFS

- AGAINST -

PHILLIP KNAPP AND D. JACKSON COLEMAN DEFENDANTS

CASE NO. 74-[illegible]

JUDGE COOLEY

CLERK'S CERTIFICATE.

I, RAYMOND F. BURGHARDT, Clerk of the District Court of the United States for the Southern District of New York, do hereby certify that the certified copy of docket entries, lettered A-13, and the original filed papers numbered 1 thru 28, and exhibits _____, inclusive, constitute the record on appeal in the above entitled proceeding; except for the following missing documents:

DATE FILED	PROCEEDINGS
NONE	

UNITED STATES COURT OF APPEALS FILED JUN 1 1974 A. DANIEL FUSARO, CLERK SECOND CIRCUIT

IN TESTIMONY WHEREOF, I have caused the seal of the said Court to be hereunto affixed, at the City of New York, in the Southern District of New York, this 1st day of JUNE, in the year of our Lord, One thousand nine hundred and seventy-four, and of the Independence of the United States the 198th year.

Raymond F. Burghardt

Clerk of the Court

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UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

U.S.C.A. NO. 76-[illegible]

ANNA R. JOHNSON & ROBERT K. JOHNSON,

-vs-

PHILLIP KNAPP, et al

U.S. DISTRICT COURT
SOUTHERN DISTRICT OF
NEW YORK

CASE NO. 74 Civ 5437

JUDGE Conner

1st SUPPLEMENTAL RECORD

INDEX TO THE SUPPLEMENTAL RECORD ON APPEAL

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Certified extract of docket entries	6
Stipulation designating exhibits	29
Clerk's Certificate	30

EXHIBITS

Plaintiff's

1. Presbyterian Hospital Record

2(a). Folder containing office record of Dr. Knapp and marked as exhibits 2, 9, 10, 11 and 12.

UNITED STATES COURT OF APPEALS
FILED
JUL 7 1976
ADMINISTRATIVE ASSISTANT TO THE CLERK
SECOND CIRCUIT

633 633

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

U.S.C.A. NO. 76-[illegible]

ANNA R. JOHNSON & ROBERT K. JOHNSON

-VS-

PHILLIP KNAPP

CASE NO. 74 Civ. [illegible]

JUDGE [illegible]

EXTRACT OF DOCKET ENTRIES

DATE	PROCEEDINGS
July 7, 1976	Filed stipulation designating exhbits for transmission to USCA as part of record on appeal.

A TRUE COPY
[illegible], Clerk
By [illegible]
Deputy Clerk

634

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

ANNA R. JOHNSON & ROBERT K. JOHNSON

-vs-

PHILLIP KNAPP, et al

CASE NO. 74 Civ 5437

JUDGE Conner

SUPPLEMENTAL CLERK'S CERTIFICATE.

I, RAYMOND F. BURGHARDT, Clerk of the District Court of the United States for the Southern District of New York, do hereby certify that the certified extract of docket entries lettered C, and the [illegible] filed papers numbered 29 thru 30, inclusive, xxxxxxxxx & plaintiff's exhibits 1 and 2(a), 2, 9,10,11 & 12 constitute the entire record on appeal in the above entitled proceeding.

[illegible]

[illegible] 7th [illegible] July [illegible]

thousand nine hundred and seventy six, and the Independence of the United States the 201st year.

Clerk of the Court.

35

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------x

ANNA R. JOHNSON and ROBERT K. JOHNSON,

Plaintiffs,

-against-

JURY DEMAND
COMPLAINT

PHILLIP KNAPP and D. JACKSON COLEMAN,

Defendants.

----------x

Plaintiffs, by their attorney, PAUL D. RHEINGOLD, complaining of the defendants, allege as follows:

FIRST CAUSE OF ACTION

1. Plaintiffs are citizens of the State of Connecticut; defendants are, upon information and belief, citizens of the State of New York; the amount in controversy exceeds $10,000, exclusive of costs and interest; hence, diversity jurisdiction exists.

2. Plaintiff Anna R. Johnson (hereafter plaintiff) was carelessly treated by defendants in 1972 and 1973 at Columbia Presbyterian Hospital and at defendants' offices.

3. As a result, plaintiff has experienced physical injury, pain and suffering, has lost earnings and incurred medical expenses, to her damage in the amount of $1 million.

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SECOND CAUSE OF ACTION

4. As a result of the matters pleaded in the First Cause of Action, plaintiff Robert K. Johnson, husband of plaintiff, has lost the services of his wife and has incurred medical expenses, all to his damage in the amount of $250,000.

Dated: New York, New York
December 10, 1974

PAUL D. RHEINGOLD
Attorney for Plaintiffs
200 Park Avenue
New York, New York 10017

637 637

-2507-

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------X

ANNA R. JOHNSON and ROBERT K. JOHNSON,

Plaintiffs,

-against-

PHILLIP KNAPP and D. JACKSON COLEMAN,

Defendants.

----------X

ANSWER

Defendant, PHILLIP KNAPP, by his attorney, ANTHONY L. SCHIAVETTI, answers the plaintiffs' complaint, upon information and belief as follows:

AS AND FOR AN ANSWER TO FIRST CAUSE OF ACTION:

FIRST: Denies each and every allegation set forth in paragraphs designated "2" and "3" of the complaint.

SECOND: Denies any knowledge or information thereof sufficient to form a belief as to the allegations set forth in paragraph designated "1" of the complaint.

AS AND FOR AN ANSWER TO SECOND CAUSE OF ACTION:

THIRD: Denies each and every allegation set forth in paragraph designated "4" of the complaint.

AS AND FOR A SEPARATE AND COMPLETE AFFIRMATIVE DEFENSE TO THE FIRST AND SECOND CAUSES OF ACTION IN THE COMPLAINT OF THE PLAINTIFFS, THE DEFENDANT ALLEGE:

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FOURTH: That any injuries sustained or suffered by the plaintiffs herein at the time and place and on the occasion mentioned in the complaint herein, were caused in whole or in part, or contributed to, by the negligence, fault and/or want of care of the plaintiffs.

WHEREFORE, the defendant demands judgment dismissing the complaint of the plaintiffs herein together with the costs and disbursements of this action.

ANTHONY L. SCHIAVETTI, ESQ.
Attorney for the Defendant
PHILLIP KNAPP
Office and P.O. Address
1633 Broadway
New York, New York 10019

BY Anthony L. Schiavetti
A MEMBER OF THE FIRM

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

- X

ANNA R. JOHNSON and ROBERT K. JOHNSON,

Plaintiffs,

-against-

STIPULATION

PHILLIP KNAPP and D. JACKSON COLEMAN,

Defendants.

- X

IT IS HEREBY STIPULATION BY AND BETWEEN the attorneys for the plaintiffs, and the attorneys for the defendants, that the defendants' answers are hereby amended to include as follows:

AS AND FOR A FIRST, FULL AND COMPLETE AFFIRMATIVE DEFENSE TO THE ALLEGATION OF LACK OF INFORMED CONSENT AS CONTAINED IN THE PLAINTIFFS' BILL OF PARTICULARS, THE DEFENDANT ALLEGES:

The cause of action of the plaintiffs, did not accrue within one (1) year before the commencement of this action and is therefore barred by the statute of limitations as set forth in Section 215 (3) of the CPLR.

DATED: NEW YORK, NEW YORK, January [illegible], [illegible]

ANTHONY L. SCHIAVETTI, ESQ.
Attorney for Defendants,
KNAPP and COLEMAN

PAUL D. RHEINGOLD
Attorney for Plaintiffs

SO ORDERED

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------X

ANNA R. JOHNSON AND ROBERT K JOHNSON,

Plaintiffs

-against-

PHILLIP KNAPP and D. JACKSON COLEMAN,

Defendant.

----------X

INTERROGATORIES

These interrogatories are addressed to Defendant, PHILLIP KNAPP, pursuant to FRCP 33.

NOTES: A. These interrogatories are continuing in nature.

B. Where documents are referred to, please identify these fully as to date made, writer, addressee, present location and custodian.

C. Where persons are referred to, please identify them by full name and present or last known address, position with defendant, if any, and present position, if known.

INTERROGATORIES

1. State your name, home and residence address and date of birth.

2. State every state where you were licensed to practice medicine and when.

3. Has your license to practice ever been removed or suspended? If so, give details.

4. Where and when did you graduate from medical school?

5. Where and when did you have internships, residencies and any other post graduate training?

6. Do you practice a special field of medicine?

7. Are you board certified in that field? If so, when?

8. What are the medical organizations and societies to which you belonged in 1972?

9. What are all the hospitals at which you had privileges or other connections in 1972? As to each state the position and year of first association.

10. Did you ever have staff privileges revoked or suspended or terminated at any hospital? If so, where and when.

11. Do you now teach or have you in the last 10 years taught at any medical schools or held any positions there? If so, which and when?

12. Have you received any honors in your profession? If so, which and when?

13. Have you authored or co-authored any articles or books? If so, please identify all books on every subject and any articles in the field of opthalmology.

14. Have you written anything on or given talks on eye surgery? If so, where and when.

15. Have you ever written or spoken on anything relating directly to plaintiff? If so, what, where and when?

16. Were you ever in the military service? If so, when and where and what rank?

17. In 1972 state each office you had for the treatment or examination of patients.

18. Have you ever been sued for malpractice before or after this suit? If so, what for, where, by whom, and what was the outcome?

19. Have you ever testified in a malpractice case where you were not the defendant? If so, on what issues and for what side, where and when?

20. Have you ever been reprimanded, criticized or censured ~~by any local, county, state or national medical organization~~? If so, please give details.

21. When did you for the first time have plaintiff as a patient?

21A. How old was plaintiff at the time?

22. List each of the dates on which you saw plaintiff professionally, giving the place of each visit.

23. What office notes or other records do you have relating to plaintiff? Itemize each as to date and event.

24. State the dates of each visit plaintiff made to your office for any purpose up until Oct. 23, 1972. As to each such visit state (a) your findings as to plaintiff's eyes and other part of her body examined; (b) the diagnoses if any which you have at the time, even if they were tentative, including "impressions;" (c) the treatment you gave, prescribed or recommended; and (d) the prognosis which you had in mind at the time, even if it was tentative.

25. At the first visit by plaintiff and any subsequent ones, up until Oct. 23, 1972, what history, including present complaints, had you received from plaintiff?

26. Did you have plaintiff admitted to Presbyterian Hospital on October 23, 1972? If so, for what purpose (state in full and as to each eye separately).

27. Did you receive in writing any consent or release form or other form from plaintiff relating to the cataract surgery performed during the October 1972 hospitalization? If so, where is it recorded and preserved?

28. (a) What are <u>all</u> of the explanations and statements you made orally or in writing to plaintiff about the proposed cataract surgery before it was performed in each eye?

(b) Please state all risks, side effects, benefits and alternatives, including non-treatment, if any, which you gave her. (c) If her husband was present, for any part of these statements, or if any were given to him rather than to her, please so indicate.

29. Did you consult with any other physician relating to the admission of the plaintiff, her condition, or the type of surgery to be performed? If so, with whom and when.

30. Please state the vision, corrected and uncorrected, in each eye as last measured before the surgery performed on the October 1972 admission.

31. What visual findings or other conditions necessitated the operations you performed.

32. On what days were the two cataract operations performed?

33. (a) Did you yourself perform each of these operations? (b) As to any portion of either which you did not yourself actually perform, state who did what and why.

34. Did the operations which you proposed go as planned? If not, in what way did they not do so.

35. Were the conditions which you believed existed before the operation determined to exist as a result of (a) the operation and (b) the pathology tissue examination, if any, after the operation? If not, in what way did they not do so?

36. (a) What was plaintiff's postoperative condition, generally and in each eye? (b) As to any conditions which did develop postoperatively, please indicate (1) what they were, (2) whether they were expected or unexpected consequences of cataract surgery, (3) with whom you consulted if anyone about them, (4) what their progress was and (5) what plaintiff's condition was at the time of discharge on November 7, 1972, as to each of them.

notes for the October 1972 admission that there was bullate keratitis in the right eye (11/7), what was the cause of this condition?

38. What was plaintiff's visual acuity at the time she left the hospital?

39. On what dates after discharged on November 7, 1972, did you see plaintiff? As to each occasion, give the data sought in 36 above.

40. Did plaintiff develop bullous keratopathy? If so, (a) when did it first appear; (b) what was the cause of it; (c) what treatment did you give it; and (d) what did you tell plaintiff about its origin, significance and prognosis?

41. (a) At any time after discharge did you refer the plaintiff to any other physician, including co-defendant? (b) If so, when and for what condition or on what basis did you so refer her?

42. What report, orally or in writing, did you give to each such doctor as to the reason for the referral and nature of plaintiff's eyes?

43. What report, if any, did you receive orally or in writing from any referring or consulting doctor as to the nature of plaintiff's eyes and the cause therefor?

44. (a) To your knowledge what treatment did co-defendant give plaintiff? (b) Were you consulted as to the treatment to be given? (c) Did you give your consent to it?

45. (a) When for the last time did you see plaintiff professionally? (b) At that time what was the status of her eyes and of her visual acuity (or give the last time that you had measured it).

46. Were you ever asked to provide any medical information on plaintiff to any other physician or institution after

April 1975. [illegible]

(c) when?

47. Did you take any photographs of plaintiff? If so, when? Please identify them fully as to date and place, number and what is portrayed.

48. What malpractice insurance of any and every kind did you have in effect when you treated plaintiff? State the policies, the carriers, the amount of coverage and dates of coverage.

49. Have you or your lawyers any information about plaintiff other than so far mentioned in answers above? If so, please identify it.

50. Who are the experts you will call to testify on your behalf, what are their fields, and what opinion will they give, on what topics, and on what basis?

Dated: April 24, 1975

PAUL D. RHEINGOLD
Attorney for Plaintiffs
200 Park Avenue
New York, N.Y.10017
661-0055

TO:

ANTHONY L. SCHIAVETTI, ESQ.
Attorney for Defendants
1633 Broadway
New York, N.Y. 10019

P72(a)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------X

ANNA R. JOHNSON AND ROBERT K. JOHNSON

Plaintiffs

-against-

PHILLIP KNAPP and D. JACKSON COLEMAN,

Defendant.

----------X

ANSWERS TO INTERROGATORIES
74 Civil 9437
(W.C.F.)

The following constitutes the defendant, PHILLIP KNAPP's answers to the interrogatories propounded to him by the plaintiffs pursuant to Rule 33 of the Federal Rules of Civil Procedure.

1. Phillip Knapp
   133 Serpentine Road
   Tenafly, N.J.
   Feb. 12, 1916

2. Iowa - 1947 to 1951
   New York - 1951 to present

3. No

4. College of Physicians & Surgeons
   Columbia University
   New York, New York
   1941

5. Bellevue Hospital, New York, N.Y. 1942 - 1944: Intern
   University Hospitals, Iowa City, Iowa
   Jan. 1, 1947 - Dec. 31, 1950: Residency in Ophthalmology
   Heed Fellowship: Portland, Oregon Jan. 1 - March 1
   Barnes Hospital, St. Louis March 1-May 1
   Boston, Mass. May 1 - June 30, 1951

6. Yes, ophthalmology.

7. Yes, 1950

645(b)

8. New York County Medical Society
New York State Medical Society
American Medical Association
New York Academy Of Medicine
New York Ophthalmological Society
American Academy of Ophthalmology & Otology
American Ophthalmological Society
Ophthalmological Society of New Jersey
International Strabismological Association
Association Research in Vision & Ophthalmology
French Ophthalmological Society

9. Columbia-Presbyterian Medical Center - Attending Surgeon - 1951
Morristown Memorial Hospital - Consultant Ophthalmologist - 1959

10. No.

11. Columbia University College of Physicians & Surgeons
Associate Professor of Clinical Ophthalmology

12. Head Foundation Award - 1970

13. Intermittent Exotropia: Evaluation and Therapy
Am. Orthoptic J. 3:27:33, 1953.

Treatment of Experimental Ocular Tuberculosis with Isoniazid by Philip Knapp & L. von Sallmann, Assoc. Res., Ophth., Proc. 22nd 1953. American J. Ophth., 38 (1-2) : 199-205, July 1954.

Use of Miotics in Esotropia by P. Knapp & N. M. Capobianco Am. Orthoptic J. 6: 40-46, 1956.

Divergent Deviation: In: Strabismus Ophthalmic Symposium 2, ed. by J. H. Allen 2 ed., St. Louis, Mosby, 1958, pp 354-363.

Treatment of Divergent Deviation: In: Strabismus Ophthalmic Symposium 2 ed., St. Louis, Mosby, 1958, pp 364-376.

The Surgical Treatment of Strabismus. In: Strabismus Ophthalmic Symposium 2, ed. by J. H. Allen 2 ed., St. Louis, Mosby, 1958 pp 377-390.

Vertical Incomitant Horizontal Strabismus. The So-Called "A" & "V" Syndrome Am. Ophthal. Soc., Trans. 57: 666-699, 1959.

Strabismus by Philip Knapp Arch. Ophthal. v. 67, pp 811-826, June 1962, Arch Ophthal. v. 70, pp 109-129, July 1963 Arch Ophthal. v. 72, pp 267-285, Aug. 1964

BEST COPY AVAILABLE

Amblyopia - Field of Vision, V. 19, #1, Spring 1965

Intermittent Exotropia, by Philip Knapp & Sally Moore
Am. Orthoptic J. Vol. 10 p 118 1960.

The Surgical Treatment of Persistent Horizontal Strabismus, by Philip Knapp

Transactions of the American Ophthal. Soc. 1965, Vol LXIII - pages 75-90. (University of Toronto Press)

The Surgical Treatment of Double-Elevator Paralysis, By Philip Knapp

Transactions of the Amer. Ophthal. Soc. 1969, Vol. 67 pages 304-323.

The Surgical Treatment of the Superior Oblique Tendon Sheath Syndrome, by

Alan B. Scott, and Philip Knapp Arch. Ophthal., Vol 88 1972.

14. See above. Also lectures at about six medical meetings a year.

15. No.

16. USNR 1944 to 1946. Pacific Theatre. Lieutenant MC.

17. 635 West 165th Street New York, N. Y. 10032

18. Refused. Not relevant to issues of this law suit.

19. Same as #18 above.

20. Same as #18 above.

21. June 19, 1970.

21A. 38.

22. Refused. The information sought herein should properly be obtained during course of an examination before trial.

23. Same as #22 above.

24. The material sought, if germaine, should properly be obtained during the course of an examination before trial.

25. Same as #24 above.

26. Yes, for cataract extraction left eye first, and right eye one week later.

27. Yes, in hospital chart.

645 (d)

28. Refused. The information sought herein should properly be obtained during the course of an examination before trial.

29. No.

30. VA OD sc 20/60+1 with +0.75 20/30- with lights out
VA OS sc 20/400 with +1.75 20/400

31. The above visual acuity which handicapped her visually due to the lens opacities.

32. Oct. 24, 1972 left eye
Oct. 31, 1972 right eye

33. Yes.

34. Yes.

35. By the operation. No pathological tissue examination of cataractous lenses.

36. a) Satisfactory.
b) Nov. 3, 1972 O. D. striate opacity of cornea.
1) Nov. 6, 1972 O. D. dense striate with thickening of cornea above
O. S. H aqueous flare with some rbcs below
2) Not unexpected.
3) No one.
4) Improved.
5) Mild striate O. D.
O. S. clear

37. Same as #28 above.

38. The left eye was 20/60, and the right was not tested.

39. Nov. 14, 1972 — Eyes injected. Not using Maxitrol as instructed, Mild striate O. D.

Nov. 21, 1972 — Slight haze upper cornea O. D. persists
VA OD cc 20/30
VA OS cc 20/25 -

Dec. 5, 1972 — VA OU cc 20/30 cornea clear
t to H aqueous flare

Dec. 19, 1972 — Trouble seeing.
No cause seen for this.

Dec. 26, 1972 — VA OD cc 20/30
VA OS cc 20/25
OD mild injection above with mild opacity on back of cornea above. Some central vitreous haze OD
Impr: change in Descemet's membrane
OS OK

645 (a)

Jan. 9, 1973	Edema of maculae OU with mild vitreous haze OD, Impr: Micro-cystic edema of maculae with mild vitritis OD as described by Irvine-Gass.
V/16 →	
Jan. 30, 1973	Same edema of maculae with VA OD cc 20/60⁻ VA OS cc 20/40⁻
Feb. 22, 1973	VA OU cc 20/30 due to edema of maculae. Referred to Dr. D. Jackson Coleman for fluorescein angiography as to leakage of B-V's causing macular edema.
Apr. 16, 1973	OD injected. Epithelial bedewing with same opacity with curved line on back of cornea. Rx: Restarted local steroid drops.
Apr. 25, 1973	Less injection, less epithelial bedewing and less haze. Rx: Continued local steroids.
May 8, 1973	OD no injection. Only mild haze of cornea with same posterior opacity. VA OS cc 20/50⁻ Reduced local steroids to b.i.d.
May 24, 1973	More corneal bedewing with haze in vitreous Impr: Vitritis assoc. with Irvine-Gass.
June 14, 1973	OD clearer OS clear Rx: Continue local steroids and Epinal b. i. d. versus any potential pressure rise due local steroids.

40. a) Developed epithelial bedewing with stromal haze on Apr. 16, 1973. Prior to that Dr. Coleman who was caring for patient in my absence had seen haze of cornea since Feb. 27, 1973.

b) Change in endothelium due to unknown cause.

c) Local steroid drops as possibly associated with iritis and vitritis of Irvine-Gass.

d) Cause undetermined. Prognosis guarded.

41. Feb. 22, 1973 to Dr. D. Jackson Coleman for intravenous fluorescein angiography to find posaible leaks causing edema of maculae.

42. Oral discussion of her condition.

43. Oral report that there was leakage of dye in each eye and he suggested photocoagulation to try to dry up maculae.

44. The information sought should properly be obtained from the co-defendant herein.

45. June 14, 1973
OD was hazy due to bedewing of corneal epithelium and posterior opacity
OS appeared OK
VA OD 20/400 due to corneal haze
VA OS cc 20/30

46. No.

47. No.

48. Personal & Professional Excess, Indemnity Policy, Aetna Casualty & Surety Co. #[illegible] Effective 3/20/72 to 3/30/73, Renewed 3/20/73 $1,000,000 limit of liability.

Employer's Insurance of Wausau #[illegible] Effective July 6, 1971 to July 6, 1972
Renewed July 6, 1972 to July 6, 1973
Limits of liability $200,000 each person aggregate 600,000 general aggregate

49. No.

50. Not determined as yet.

ANTHONY L. SCHIAVETTI
Attorney for Defendant
PHILIP KNAPP
Office and P. O. Address
1633 Broadway
New York, New York 10019

BEST COPY AVAILABLE

646

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
- -x

ANNA R. JOHNSON and ROBERT K. JOHNSON,

Plaintiffs,

-against-

PHILLIP KNAPP and D. JACKSON COLEMAN,

Defendants.

- -x

SUPPLEMENTARY ANSWERS TO INTERROGATORIES

74 Civil 5437 (W.C.C.)

25074

The following constitutes the defendant PHILLIP KNAPP's answers to interrogatories numbered 18, 19, 20, 22, 23, 24, 25, 28, 37, and 44 propounded to him by the plaintiff herein, pursuant to the direction of the Hon. William C. Connor, Judge, United States District Court, Southern District of New York.

18. 1955. Bad glasses. Small Claims Court, Brooklyn, New York - dismissed.

19. No.

20. No.

22. 6/19/70 - office visit; 11/18/70 - office visit; 9/15/71 - office visit; 9/18/72 - office visit; 10/24/72 - hospital - surgery; 10/25/72 - hospital visit; 10/26/72 - hospital visit; 10/27/72 - hospital visit; 10/28/72 - hospital visit; 10/30/72 - hospital visit; 10/31/72 - hospital - surgery; 11/1/72 - hospital visit; 11/2/72 - hospital visit; 11/3/72 - hospital visit; 11/4/72 - hospital visit; 11/6/72 - hospital visit; 11/7/72 - hospital visit; 11/14/72 - office visit; 11/21/72 - office visit; 12/5/72 - office visit; 12/19/72 - office visit; 12/26/72 - office visit; 1/9/73 - office visit; 1/16/73 - office visit; 1/30/73 - office visit; 2/22/73 - office visit; 4/16/73 - office visit; 4/25/73 - office visit; 5/8/73 - office visit; 5/24/73 - office visit and 6/14/73 - office visit.

23. 6/19/70 - initial eye exam; 11/18/70 - followup eye exam; 9/15/71 - followup eye exam; 9/18/72 - followup eye exam; 10/24/72 - Intracapsular cataract extraction with peripheral iridectomy OS.; 10/25/-10/30/72 - post-op examination; 10/31/72 - Intracapsular cataract extraction with peripheral iridectomy OS., Nov. 1-7, 1972 - post-op examinations; Nov. 14, 1972 inclusive of June 14, 1973 same as answered in question No. 39.

D

647

24. 6/19/70, 11/18/70, 9/15/71 and 9/18/72.

(a) Posterior subcapsular opacities in each lens.
(b) DX: incipient cataracts.
(c) None.
(d) Good.

25. First visit: "General health fine, no high blood pressure, no diab., cataracts both eyes. No glasses. Felt two years ago something was wrong. Went to Dr., he didn't tell her - he was to tell her husband - he forgot. Went to another Dr. in Feb. - told about cataracts. But in 1972, vision much worse. Unable to read newspaper."

28. (a) Told better than 90% chance of success without listing specific causes of failure.
(b) Same as above plus it is an elective procedure that is done when patient desires it because of visual handicap.
(c) Husband present at all visits.

37. There is always some trauma to the cornea during lens removal causing damage to the endotheluim. This may occur at the time of enlarging the incision with ~~sutures~~, or at the time of lens removal.

44. (a) Argon laser to peri-macular area OS. OD not done as cornea became hazy.
(b) Yes.
(c) Yes.

DATED: NEW YORK, NEW YORK
September 25, 1975

PHILLIP KNAPP, M.D.

Subscribed and sworn to before me
this day of 1975.

NOTARY PUBLIC

TO:

PAUL D. RHEINGOLD
Attorney for Plaintiffs
200 Park Avenue
New York, New York 10017

648

99-25074

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------X

ANNA R. JOHNSON and ROBERT K. JOHNSON,

Plaintiffs,

-against-

PHILLIP KNAPP and D. JACKSON COLEMAN,

Defendants.

----------X

ANS TO

INTERROGATORIES

INTERROGATORIES ADDRESSED TO PLAINTIFF BY DEFENDANT PHILLIP KNAPP PURSUANT TO RULE 33 OF THE FEDERAL RULES OF THE CIVIL PROCEDURE TO BE ANSWERED IN WRITING AND UNDER OATH WITHIN FIFTEEN (15) DAYS OF RECEIPT THEREOF: SAID INTERROGATORIES ARE TO BE DEEMED CONTINUING UP TO AND INCLUDING THE OATH OF TRIAL. IF THE PLAINTIFFS OR THEIR ATTORNEYS ACQUIRE ANY FURTHER INFORMATION RELEVANT TO THESE INTERROGATORIES AFTER ANSWERING SAME, SUPPLEMENTAL ANSWERS TO THESE INTERROGATORIES EMBODYING SAID INFORMATION ARE TO BE FORWARDED IMMEDIATELY TO THE ATTORNEYS FOR THE DEFENDANT PHILLIP KNAPP.

Q1. The dates and times of day of each of the alleged negligent acts and/or omissions which will be alleged and claimed against the answering defendant herein.

Q2. The exact location of each of the alleged negligent acts, and/or omissions charged against the answering defendant herein, if in a hospital state in what part of the said hospital each alleged negligent act took place.

Q3. A statement of each and every act or omission which you will claim as the basis of the alleged malpractice of the answering defendant herein.

Q4. State the condition or conditions which it is claimed this defendant undertook to treat and upon which plaintiffs' complaint is based.

6.49

Q5. If there are any claims of vicarious liability against the answering defendant herein, state the names of each and every person who performed the acts or failed to act and if the names are not know, describe them by physical appearances or occupations with sufficient clarity to make ready identification.

Q6. State the injuries the plaintiff suffered as the result of the alleged negligence and/or malpractice of the answering defendant herein stating which injuries plaintiff will claim to be permanent.

Q7. State the length of time plaintiff was confined to each of the following by virtue of the acts or omissions of the answering defendant herein:

(a) Bed,
(b) House,
(c) Hospital.

Q8. State separately the toral amounts claimed by the plaintiff as special damages for each of the following:

(a) Physicians' services,
(b) Nurses' services,
(c) Medical supplies,
(d) Hospital expenses, with the names and addresses of all hospitals, and dates of admission and discharge from each hospital,
(e) Loss of earnings,
(f) Any other expenses.

Q9. State the:

(a) Occupation of the plaintiff,
(b) Name and address of her employer; if self-employed, state the address of her place of employment and the type of business or occupation in which she was engaged immediately prior to the occurrence.
(c) The length of time plaintiff was unable to attend her employment.
(d) Plaintiff's average weekly earnings.
(e) The amount of money plaintiff was alleged to have earned during the year prior to the occurrence.
(f) The amount of earnings the plaintiff was alleged to have lost as a result of the occurrence.

Q10. State the date of birth of the plaintiff.

Q11. State the residence address of the plaintiff.

Q12. Set forth how long it will be claimed plaintiff, husband, ROBERT K. KOHNSON will claim he was deprived of the service of plaintiff, wife, ANNA R. JOHNSON.

650

DATED: New York, New York
Fegruary 25, 1975

Yours, etc.,

ANTHONY L. SCHIAVETTI, ESQ.
Attorney for the Defendant
PHILLIP KNAPP
Office and P.O. Address
1633 Broadway
New York, New York 10019

BY anthony l. schiavetti
A MEMBER OF THE FIRM

TO: PAUL D. RHEINGOLD, ESQ.
Attorney for Plaintiffs
200 Park Avenue
New York, New York 10017

651

-2507-

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------X

ANNA R. JOHNSON and ROBERT K. JOHNSON,

Plaintiffs,

-against-

PHILLIP KNAPP and D. JACKSON COLEMAN,

Defendants.

----------X

INTERROGATORIES

INTERROGATORIES ADDRESSED TO PLAINTIFFS BY DEFENDANT D. JACKSON COLEMAN PURSUANT TO RULE 33 OF THE FEDERAL RULES OF THE CIVIL PROCEDURE TO BE ANSWERED IN WRITING AND UNDER OATH WITHIN FIFTEEN (15) DAYS OF RECEIPT THEREOF: SAID INTERROGATORIES ARE TO BE DEEMED CONTINUING UP TO AND INCLUDING THE OATH OF TRIAL. IF THE PLAINTIFFS OR THEIR ATTORNEYS ACQUIRE ANY FURTHER INFORMATION RELEVANT TO THESE INTERROGATORIES AFTER ANSWERING SAME, SUPPLEMENTAL ANSWERS TO THESE INTERROGATORIES EMBODYING SAID INFORMATION ARE TO BE FORWARDED IMMEDIATELY TO THE ATTORNEYS FOR THE DEFENDANT D. JACKSON COLEMAN.

Q1. The dates and times of day of each of the alleged negligent acts and/or omissions which will be alleged and claimed against the answering defendant herein.

Q2. The exact location of each of the alleged negligent acts, and/or omissions charged against the answering defendant herein, if in a hospital state in what part of the said hospital each alleged negligent act took place.

Q3. A statement of each and every act or omission which you will claim as the basis of the alleged malpractice of the answering defendant herein.

Q4. State the condition or conditions which it is claimed this defendant undertook to treat and upon which plaintiffs' complaint is based.

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Q5. If there are any claims of vicarious liability against the answering defendant herein, state the names of each and every person who performed the acts or failed to act and if the names are not know, describe them by physical appearances or occupations with sufficient clarity to make ready identification.

Q6. State the injuries the plaintiff suffered as the result of the alleged negligence and/or malpractice of the answering defendant herein stating which injuries plaintiff will claim to be permanent.

Q7. State the length of time plaintiff was confined to each of the following by virtue of the acts or omissions of the answering defendant herein:

(a) Bed,
(b) House,
(c) Hospital.

Q8. State separately the total amounts claimed by the plaintiff as special damages for each of the following:

(a) Physicians' services,
(b) Nurses' services,
(c) Medical supplies,
(d) Hospital expenses, with the names and addresses of all hospitals, and dates of admission and discharge from each hospital,
(e) Loss of earnings,
(f) Any other expenses.

Q9. State the:

(a) Occupation of the plaintiff,
(b) Name and address of her employer; if self-employed, state the address of her place of employment and the type of business or occupation in which she was engaged immediately prior to the occurrence.
(c) The length of time plaintiff was unable to attend her employment.
(d) Plaintiff's average weekly earnings.
(e) The amount of money plaintiff was alleged to have earned during the year prior to the occurrence.
(f) The amount of earnings the plaintiff was alleged to have lost as a result of the occurrence.

Q10. State the date of birth of the plaintiff.

Q11. State the residence address of the plaintiff.

Q12. Set forth how long it will be claimed plaintiff, husband, ROBERT K. JOHNSON will claim he was deprived of the service of plaintiff, wife, ANNA R. JOHNSON.

653

DATED: New York, New York
February 25, 1975

Yours, etc.,

ANTHONY L. SCHIAVETTI, ESQ.
Attorney for the Defendant
D. JACKSON COLEMAN
Office and P.O. Address
1633 Broadway
New York, New York 10019

BY _____
A MEMBER OF THE FIRM

TO: PAUL D. RHEINGOLD, ESQ.
Attorney for Plaintiffs
200 Park Avenue
New York, New York 10017

-against- 607

PHILLIP KNAPP and D. JACKSON COLEMAN,

Defendant.

----------X

INTERROGATORIES

Plaintiff provides the following answers to interrogatories demanded by Defendant, PHILLIP KNAPP, pursuant to FRCP 33:

1. During the admission at Columbia Presbyterian October 23 - November 7, 1972, at various times precisely unknown to plaintiffs but including the performance of the two cataract operations on 10/24 and 10/31, and in the post-operative care at the hospital. Further at all times following discharge and while plaintiff still remained a patient of this defendant up until about May, 1973. In addition, it is possible that this defendant will also be charged with negligence before the October 1972 admission, while plaintiff was a patient of this defendant, but plaintiff has not yet had discovery from this defendant or any other defendant and hence cannot give a better answer at present than is set forth above.

2. Stated as best as can be set forth in 1 above.

3. Operating on the eyes when it was not necessary and was dangerous and contraindicated, and based upon a failure to analyze the underlying conditions. Improper performance of operation, including damage to the cornea, vitreous and retina. Failure to treat and correct injuries and other conditions which resulted from the operation, including striate keratitis and bullous keratopathy and other conditions which later developed, as listed in 6 below.

condition and improper consultation with co-defendant as to the proper treatment, together with improper followup on the work done by co-defendant and others.

Failure to obtain an informed consent for treatment rendered.

Causing permanent and irreversible eye damage.

4. The conditions from which plaintiff suffered after being operated upon by the co-defendant are those which this defendant was asked to treat; their exact nature is still unknown as we have had no discovery. However, they include those conditions stated in 6 below.

5. Yes. co-defendant and perhaps residents at Presbyterian Hospital who participated in the operations and treatment, the names of which are presently unknown to plaintiffs, but are the subject of discovery.

6. Keratitis, bullous keratopathy; photocoagulation of eye, corneal thickening; cystoid macular edema; synechia to the anterior hyaloid face; marked folding of Descement's membrane; central guttata; diffuse pigmentary disturbance in macula with a leak; retinal pigment epithelium; several unsuccessful corneal transplant; blindness; pain and suffering; mental and physical; interference with normal family life. All of the above are permanent and new conditions may appear as a result of the ones cited above.

7. (a) Approximately two weeks.
(b) Still so confined.
(c) Approximately three weeks.

8. (a) $5,500.
(b) None.
(c) To be supplied.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

6076

----------X

ANNA R. JOHNSON AND ROBERT K. JOHNSON,

Plaintiffs,

-against-

PHILLIP KNAPP and D. JACKSON COLEMAN,

Defendant.

----------X

ANSWERS TO INTERROGATORIES

Plaintiff provides the following answers to interrogatories demanded by Defendant, D. JACKSON COLEMAN, pursuant to FRCP 33:

1. All the times when plaintiff was under this defendant's care, which runs from about November 1972 until May 1973, and especially at the times when defendant treated her, as with the laser photocoagulation. Plaintiff does not have precise records and intends to make this a subject of discovery, which she has not had from any defendant yet.

2. At his office and at Presbyterian Hospital, exact section unknown.

3. Improper diagnosis of condition in eyes.

Improper treatment, in that treatment given (coagulation) was not indicated, was dangerous, was not calculated to cure the conditions and tended to conceal and make impossible to treat the underlying condition.

Improper advice to co-defendant and others as to nature of her conditions and their proper treatment.

Failure to treat the correct post-operative conditions, such as those listed in Par. 6 below.

Failure to obtain consultation.

(c) Improper performance of operation, including damage to the cornea, vitreous and retina.

Failure to treat and correct injuries and other conditions which resulted from the operation, including striate keratitis and bullous keratopathy and other conditions which later developed, as listed in 6 below.

Failure to obtain proper consultation for her condition and improper consultation with co-defendant as to the proper treatment, together with improper followup on the work done by co-defendant and others.

Failure to obtain an informed consent for surgery and later treatment.

Causing permanent and irreversible eye damage.

4. Originally the conditions which led to the October 1972 hospitalization, stated by defendant to be "posteriour subcapsular opacities." Then, there were the conditions stated in 3 above and 6 below, resulting from the surgery, which were not treated properly.

5. Yes. Co-defendant and perhaps residents at Presbyterian Hospital who participated in the operations and treatment, the names of which are presently unknown to plaintiffs but are the subject of discovery.

6. Keratitis; bullous keratopathy; photocoagulation of eye; corneal thickening; cystoid macular edema; synechia to the anterior hyaloid face; marked folding of Descement's membrane; central guttata; diffuse pigmentary disturbance in macula with a leak; retinal pigment epithelium; several unsuccessful corneal transplant; blindness; pain and suffering, mental and physical; interference with normal family life. All of the above are

cited above.

658

7. (a). Approximately two weeks.

(b). Still so confined.

(c). Approximately three weeks.

8. (a). $5500.

(b). None.

(c). To be supplied.

(d). Presbyterian Hospital, 10/23 - 11/7/72 $1765.

Yale New Haven Hospital,

1/5 - 16/74 $1954

3/11 - 15/74 $709

1/10 - 18/75 $1627

2/2 - 28/74 $3521

(e). None.

(f). Household help $1200 and continuing.

Note: Medical expenses are continuing.

9. Plaintiff is a housewife.

10. 10/17/32.

11. 271 Sport Hill Road, Easton, Connecticut.

12. Permanently.

Sworn to before me this

day of , 1975.

ANNA R. JOHNSON

658

TO: ANTHONY L. SCHIAVETTI, ESQ.
Attorney for Defendants
1633 Broadway
New York, N.Y. 10019

(d). Presbyterian Hospital, 10/23 - 11/7/72 $1765.

Yale New Haven Hospital,

1/5 - 16/74	$1954
3/11 - 15/74	$709
1/10 - 18/75	$1627
2/2 - 28/75	$3521

(e). None.

(f). Household help $1200 and continuing.

Note: Medical expenses are continuing.

9. Plaintiff is a housewife.

10. 10/17/32.

11. 271 Sport Hill Road, Easton, Connecticut.

12. Permanently.

Sworn to before me this

day of , 1975.

ANNA R. JOHNSON

TO:

ANTHONY L. SCHIAVETTI, ESQ.
Attorney for Defendants
1633 Broadway
New York, New York 10019

66U

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
----------x

ANNA R. JOHNSON and ROBERT K. JOHNSON,

Plaintiffs,

-against-

PHILLIP KNAPP and D. JACKSON COLEMAN,

Defendants.

----------x

74 Civ. 5437 (WCC)

PLAINTIFFS' REQUESTS TO CHARGE

1. A physician who renders medical service is obligated to have that reasonable degree of knowledge and ability that is expected of like specialists who do the sort of examination, treatment and operations involved. The law recognizes that there are differences in the abilities of doctors, just as there are in the abilities of people engaged in other activities. To practice his profession a doctor is not required to be possessed of the extraordinary knowledge and ability that belongs to a few men of rare endowments, but he is required to keep abreast of the times and to practice in accordance with the approved methods and means of treatment in general use. The standard to which he is held is measured by the degree of knowledge and ability of the average ophthalmologist.

In performing a medical service the doctor is obligated to use his best judgment and to use reasonable care in the exercise of his knowledge and ability. The rule requiring hi to use his best judgment does not make him liable for a mere

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error of judgment, provided he does what he thinks is best after careful examination. The rule of reasonable care does not requi the exercise of the highest possible degree of care; it requires only that he exercise that degree of care that a reasonably prudent ophthalmologist would exercise under the same circumstances.

If a patient should sustain an injury while undergoing medical care and that injury results from the doctor's lack of knowledge or ability, or from his failure to exercise reasonable care or use his best judgment, then he is responsible for the injuries that are the result of his acts.

Source: NY PJI 2:150

Rheingold & Davey, Standard of Care in New York Medical Malpractice Cases, 45 N.Y.S. Bar J. 7, 98.

2. A physician is under a duty to divulge to his patien the risks which singly or in combination, tested by general conditions of reasonable disclosure under all the circumstances, will materially affect the patient's decision whether to proceed with the proposed treatment. The patient may always choose between apparent dangers, one attendant upon the surgery, the other resulting from the continuation of an existing condition because of a decision not to undergo surgery. The issue is whether a reasonably prudent person in the patient's circumstances, if reasonably informed of the significant perils, would have decided to assent to the surgery.

Garone v. Roberts' Technical and Trade School, Inc. 47 A.D.2d 306, 366 N.Y.S.2d 129 (1975)

669

Zelesnik v. Jewish Chronic Disease Hospital
47 A.D.2d 199, 366 N.Y.S.2d 163 (1975)

Fogal v. Genesee Hospital
41 A.D.2d 468, 344 N.Y.S.2d 552 (1973)

All three cases relying on the leading case of Canterbury v. Spence, 464 F.2d 772 (1972).

Dated: New York, New York
April 19, 1976.

PAUL D. RHEINGOLD, ESQ.
Attorney for Plaintiffs
200 Park Avenue
New York, N.Y. 10017
(212) 661-0055

663

United States Court House in the Borough of Manhattan, City of New York on the 26th day of APRIL in the year of our Lord, One Thousand Nine Hundred and Seventy-SIX

PRESENT:
HONORABLE: JUDGE CONNER
United States District Judge.

ANNA R. JOHNSON
ROBERT K. JOHNSON
VS
DR. PHILLIP KNAPP
DR. JACKSON COLEMAN

Docket No. 74 Civ 5437 W.C

Now comes the Plaintiff by OVER

and moves the trial of this cause. Likewise comes the Defendant by OVER

Thereupon a Jury is duly empaneled and sworn, and the cause proceeds to Trial.

JURY TRIAL BEGUN
TRIAL CONT'D
TRIAL CONT'D - DEFT'S MOTION TO DISMISS COMPLAINT AS TO DEFT JACKSON COLEMAN GRANTED
Apr. 29, 1976 TRIAL CONT'D. - ADJ'D. TO MAY 3
MAY 3 TRIAL CONT'D - CONCLUDED - JURY DELIBERATING
May 4, 1976 - JURY DELIBERATING — VERDICT. FOR DEFT.

QUESTIONS TO BE ANSWERED BY THE JURY ATTACHED

664

QUESTIONS TO BE ANSWERED BY THE [illegible]

1. Did Dr. Knapp fail to use the skill and care of an ordinary opthalmologist at the time and place in question?

NO
(Yes or No)

(If the answer to Question 1 is "No," no further questions need be answered.)

2. If the answer to Question 1 is "Yes," was such a lack of skill and care a competent producing cause of Mrs. Johnson's blindness?

_____
(Yes or No)

(If the answer to Question 2 is "No," no further questions need be answered.)

3. If the answer to both Question 1 and Question 2 is "Yes," what amount of damages will fairly compensate Mrs. Johnson and her husband for the injury or loss they have suffered?

Mrs. Johnson: $_____

Mr. Johnson: $_____

Richard L Block
Jury Foreman

24

NEW YORK, N.Y. 10019

27

Even we found Dr Knapp not guilty of malpractice as set down in the questions directed to the Jury by the Judge, we feel that according to juris testamony Dr Knapp failed to establish a sound patient-doctor relationship.

Anthony L. Schiavetti, Esq., Attorney for Defendants
1633 Broadway
New York, N.Y. 10019

666

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

- X

ANNA R. JOHNSON
ROBERT K. JOHNSON

Plaintiffs :

-against-

DR. PHILLIP KNAPP
DR. JACKSON COLEMAN

Defendants :

- X

74 Civil 5437 (WCC)

JUDGMENT

MICROFILM
MAY 8 1976

The issues in the above entitled action having been brought on regularly for trial, before the Honorable William C. Conner, United States District Judge, and a jury, on April 26,27,28,29 and May 3 and 4, 1976, and the Court having granted the motion to dismiss as to defendant Dr. Jackson Coleman, and the Court having submitted the attached special questions to the jury, and the jury having answered the said questions, and the jury thereafter having returned a verdict in favor of the defendant, it is,

ORDERED, ADJUDGED and DECREED: That defendant DR. PHILLIP KNAPP have judgment against plaintiffs ANNA R. JOHNSON and ROBERT K. JOHNSON dismissing the complaint, and it is further,

ORDERED: That the complaint be and it is hereby dismissed as to defendant DR. JACKSON COLEMAN.

Dated: New York, N.Y.
May 7, 1976

Raymond F. Burghardt
Clerk

APPROVED:

William C. Conner
U.S.D.J.

666 (a)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF

NEW YORK

ANNA R. JOHNSON and ROBERT K. JOHNSON	)	
Plaintiffs,	)	CIVIL ACTION NO. 74-5437
-against-	)	
PHILLIP KNAPP and D. JACKSON COLEMAN,	)	
Defendants	)	

PLAINTIFFS' NOTICE OF APPEAL

Notice is hereby given that the plaintiffs hereby appeal to the United States District Court of Appeals for the Second Circuit from the judgment entered by the United States District Court herein on the 4th day of May, 1976.

Dated May 17, 1976, at Bridgeport, Connecticut.

HELEN F. KRAUSE
Attorney for Plaintiffs
P.O. Box 64
Trumbull, Connecticut, 06611

THE PRESBYTERIAN HOSPITAL 667
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER
APPLICATION (PLEASE PRINT)

FOR DATA PROCESSING USE ONLY

VC CHG.	BLDG.	FLOOR & ROOM NO.	PUBLISHED ROOM RATE

CHARGED ROOM RATE	SERV.	CLASS	BOARD.	SEX	BILL DEST.	GEO. LOC.	MOTHER'S UNIT NO.

PATIENT'S FIRST NAME: ANNA | MIDDLE: R. | LAST: JOHNSON | UNIT NUMBER: 218-12-40

APT. | HOW LONG THERE?

ADDRESS: 217 SPORT HILL ROAD

CITY: EASTON | STATE: CONN | ZIP CODE: 06425 | AREA CODE TEL. NO: 203-372-5438

AGE: 40 | BIRTHDATE: MONTH 09 DAY 17 YEAR 32 | CIRCLE: MALE / FEMALE | SINGLE / MARRIED / WIDOWED / SEP. / DIVORCED / LIV.

FATHER'S FULL NAME: JOHN | DEC. / LIV.

HUSBAND'S OR WIFE'S NAME: ROBERT | DEC.

MOTHER'S FULL MAIDEN NAME: CAROLINE | DEC. / LIV.

RACE & NATIONALITY: WHITE/AMERICAN

BIRTHPLACE: BRIDGEPORT, CONNECTICUT

YEARS IN U.S.	IN N.Y. STATE	IN N.Y. CITY
40		

TEMPORARY OR FORMER ADDRESS

OCCUPATION: HOUSEWIFE | RELIGIOUS PREFERENCE: PROTESTANT | SOCIAL SEC. NO.: 064-25-0975

EMPLOYER'S NAME AND ADDRESS: Husb = self-emp at home addres. | AREA CODE TEL. NO: 203 = 268-6578

HAVE YOU EVER HAD AN EXAMINATION OR AN X-RAY ANYWHERE IN THIS MEDICAL CENTER?

WHAT IS YOUR TROUBLE? | WHAT HOSPITAL, CLINIC, OR DOCTOR REFERRED YOU HERE?

WAS THIS AN ACCIDENT? | AT WORK? | IF YOU HAVE HOSPITAL INSURANCE, LIST POLICIES BELOW

INSURANCE COMPANY	POLICY OR CERTIFICATE NUMBER	STATUS
1. CONNECTICUT BLUE CROSS, INC	M-34880 DP-115 GR: 9915-62	Nefiled 10-23-72 MF
2.		
3.		

RESERVED FOR HOSPITAL OFFICE USE OMIT THIS SECTION AND TURN PAGE

AVAILABLE RELATIVE | RELATIONSHIP

ADDRESS | AREA CODE TEL. NO:

NEXT OF KIN (LIVING): Robert K. | RELATIONSHIP: Husband

ADDRESS: same aspatient | AREA CODE TEL. NO:

BILL TO: PATIENT IN ROOM | COMPENSATION? | REG. NO. 33899

ADM. DIAG. IMPRESSION: CATARACT OS | DOCTOR: Knapp

RATINGS PLEASE CIRCLE	MEDICARE	A.H.S.	CITY	STATE AID	OTHER WELFARE	GRANTS	PERSONNEL AND DEPENDENTS	OTHER: SPECIFY:

ADMISSION DATE & TIME	TEL.EXT.	LOCATION-SERVICE-CLASS	RATING	DISCHARGE DATE & TIME
10-23-72 @ 1:15 PM	4749	EO 308-1 OPHTH SP	$ 93	NOV 7 1972 9:40 AM
	11 to Exhibit		1	

NICK NAME, WRITE IT HERE.

BEST COPY AVAILABLE

668

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER
CONTINUATION SHEET

Name MRS. ANNA JOHNSON Age 40
Unit No.
Location SP 308

PHILIP KNAPP, M.D.

This is the first Edward S. Harkness Eye Institute admission of this 40 year old female with cataracts, O.U.

When seen on 9/18/72 examination showed:

V.O.D. sc. 20/60 + 1
V.O.S. sc. 20/400

O.D. +0.75 20/30-
O.S. +1.50 20/400
~~add +1.75~~
O.D. reads 2[illegible]0-

Exterior and anterior segments OK
T.O.U. #15 Neo
Posterior subcapsular opacities, more O.S.
Fundi: O.D. OK
O.S. Dimly seen

℞ Cataract extraction, O.S.
(O.D. one week later)

Knapp

10-25 Med p.o. q.i.d. x 5 days
~~Cvatrol ointment~~
A.C. & pupil O.K. Knapp

10-26 Cornea A.C. & pupil O.K. Knapp

10-27 +2.5 O.E.

10-30 O.S. clear & healed Knapp

10-31 D/C O.D. D.S.T. Knapp

669

11-1 DO mud reading & marked strate (compare) Knapp

11-2 & 3 ~~00~~ ms Knapp

11-4 Strate persists Cont' need temp of D.S. Knapp

11-6 checked in office OD marked strate above bit AC OK.

D.S. - Temp of 70/60 = unstable

to improve:
~~Annular return to flare~~
Hybrid OK. ~~Circulate in Lower drill~~
Init. OK.

Knapp

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

OPHTHALMOLOGY ADMISSION EXAMINATION

6-70 218 12 40

JOHNSON ANNA
09-17-32 F

Date:

This is the 1st Eye Institute admission of this 40 yo ♀ c Cat OU

Past History:

Illnesses: 0

Operations: 0

Allergies: 0 asthma 0

Medications: 0

Endocrine History: diabetes 0 thyroid ♀

Review of Systems:

ENT: teeth 0

Resp:

Cardiovasc: 0

GI:

GU:

Neuro:

Other:

Physical Examination:

Vital Signs: BP 150/90 Pulse 80/m Temp 98.4°F Resp 20/m

ENT: WNL

Lungs: Clear to A+P

Heart: WS1, no ☐

Abdomen: Soft, no masses

Extremities: WNL

IMPRESSION: Stable Cond.
Cat OU

EYE INSTITUTE • NEUROLOGICAL INSTITUTE

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

PERI-OPERATIVE NOTES

671
E 32

218 12 40
JOHNSON ANNA
09-17-32 F

PRE-OP NOTES:

See typed sheet

Date 10-23-72 Operating Surgeon Kraft

Date Attending Surgeon

Local xylocaine

Anesthesiologist

N NOTES: 6 1/4 Date 10/24/72

(Complete all relevant items.)

ve diagnosis: Cat OS

ive diagnosis: Same

TCCE ± DJ OS

Knuth
Sup
Local

Attending Surgeon: Knuth

Scrubbed or present throughout: (Yes) No

Anesthesiologists:

blood loss:

peration:

d degree of bleeding:

cks, catheters, etc.:

dies, grafts, implants, etc.:

s (including antibiotics) in OR:

ions in OR: None

at close of operation: Good.

l information: (comments, bone flaps, plaster casts, etc.)

Signed: [signature] M.D.

Member of Operating Team

NOTE:

I.D. ~~some injection~~ Lenses ~~foam~~ stitch ~~OS clear cornea~~ A.C. injected O/z OS

Allow home.

11-7-72

[signature] M.D.

673

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

Name Johnson, Anna Age
Unit No. 218 12 40
Location E. I. 308

OPERATION REPORT

Operator-Dr. Knapp Assistant-Dr. Pico Date Oct. 2

Operations Intracapsular cataract extraction, with peripheral iridect

Preop. Dx.: Cataract OS.

With the patient under adequate sedation, the area about the left eye was prepped with iodine and alcohol in the usual manner. Anesthesia and akinesia were obtained by injection of Xylocaine and Wydase throughthe O'Brien, and retrobulbar techniques. The eye was covered with a sterile dressing. The conjunctival sac was irrigated with Neosporin and Epinephrine 1 in 10,000 dilution. A lid speculum was placed between the lids and 4% Cocaine was injected under the superior rectus muscle. A superior rectus suture of 4-0 black silk was passed and used as traction.

A conjunctival incision was done superiorly and extended up to 180°. The conjunctiva was dissected. Corneal incision was done with the keratome at 12 o'clock and the incision was extended laterally up to 180°. Three corneoscleral sutures of 6-0 plain catgut were put in place. These sutures were looped out of the incision. The cornea was retracted and a peripheral iridectomy was done at 12 o'clock. Alpha Chymar Tripsin was injected into the anterior chamber and through the peripheral iridectomy and left in place for about 1½ minutes. The cornea was again retracted and the cataract was extracted with the Amolis cryo-extractor, with no complicati The corneoscleral sutures were tied and two extra corneo-scleral sutures were put in place at 2 and 10 o'clock. The conjunctiva was closed with interrupted sutures of 6-0 plain catgut.

Neosporin ointment was instilled in the eye. The eye was covered with a sterile dressing. The patient tolerated the procedure well and left the operating room in good condi

Dr. G. Pico
MST:RK 10/30/72

Knapp

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

Name
Unit No. 218-12-40
Location SP 308

INFORMED CONSENT FOR SURGICAL OPERATIONS, DIAGNOSTIC AND OTHER THERAPEUTIC PROCEDURES 674

Date . . October 23, 1972. . . . . .

Permission is hereby given for the administration of any anesthetic and the performance of any surgical operation, diagnostic procedure, therapeutic procedure or blood transfusion on:

. . . . . MRS. ANNA JOHNSON. . . . . .

that the physicians and surgeons in attendance at The Presbyterian Hospital in the City of New York may deem advisable; and if amputation of any part or removal of any organs or tissues is considered necessary, such physicians and surgeons are authorized to effect such amputation or removal and to make any disposition they may deem proper of the parts and tissues removed.

Restrictions: . . . . . .

. . . . . .

. . . . . .

I hereby certify that I understand the above authorization and that there are risks of possible complications. I knowingly waive and decline any further information. All questions which I have asked have been answered by

Dr. . . . . (Signature)

Dr. . . . . (Signature)

Witness: . . . . . Signed . . . . . (Patient)

When patient is a minor or incompetent to give consent:

Witness: Mrs. J. Murphy . . . . . Signed . . . . . Anna R. Johnson
Signature of person authorized to consent for patient

Relationship to patient . . . . . .

7261-00

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

OPERATION REPORT

Name Johnson, Anna Age
Unit No. 218 12 40
Location E. I. 308

675

Operator-Dr. Knapp Assistant-Dr. Green Date Oct. 31,

Operations Intracapsular cataract extraction OD, with peripheral iridec

Preop. Dx.: Cataract OD.

Anesthesia: Local.

With the patient under adequate preoperative sedation, anesthesia and akinesia were obtained by means of the O'Brien, Van Lint and retrobulbar injections of 2% Xylocaine with Wydase. The skin and lids about the right eye were prepared with iodine and alcohol and draped as a sterile field in the usual manner. The right conjunctival sac was then irrigated with Argyrol, Epinephrine and Neospor and a lid speculum was placed between the lids. A 4-0 black silk traction suture was then placed beneath the belly of the superior rectus muscle. This was removed at the end of the operation. A lateral canthotomy was then performed, and this was closed at the end of the operation.

A limbal based conjunctival flap was developed and was extended 180°. The anterior chamber was entered with a keratome, and the corneoscleral incision was enlarged 180° with the corneoscleral scissors. Three 6-0 plain catgut sutures were then placed across the corneoscleral wound and looped aside. The cornea was retracted and a peripheral iridectomy was performed with the iris scissors. Chymar Tripsin enzyme was then injected into the anterior chamber and was subsequently irrigated out, after a minute and a hal The cornea was then retracted again and the anterior pole of the lens was grasped with the cryo-extractor and the lens was delivered intact without complications. The previously placed corneoscleral sutures were drawn, tightened, tied and cut. Two additional corneoscleral sutures were put in plac and they too were drawn, tied and cut. The conjunctiva was then closed with 6-0 plain catgut sutures.

Neocortef ointment was then applied to the eye and a sterile monocular dressing was also applied to the eye. The patient left the operating room in good condition, having tolerated the procedure well.

Dr. Green
MST:RK 11/11/72

Knapp

ON NOTES: 676 Date 10/31/72

Complete all relevant items.)

ive diagnosis: Cataract OD

tive diagnosis: Cataract OD

TCCE OD

Knapp

Attending Surgeon:

Scrubbed or present throughout: (Yes) No

Anesthesiologists:

blood loss: 3cc

operation:

d degree of bleeding:

cks, catheters, etc.:

dies, grafts, implants, etc.:

s (including antibiotics) in OR: ophthacort OD

ons in OR: none

at close of operation: good

information: (comments, bone flaps, plaster casts, etc.)

Signed: D. Khan M.D.

Member of Operating Team

NOTE:

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

677

218 12 40
JOHNSON ANNA
09-17-32 F

UNIT NUMBER 218 12 40

LOC 308-1 | NAME JOHNSON ANNA

P SP WD | DATE OF BIRTH 09-17-32 F | DATE OBTAINED 10/23

ORDERED BY DR. Knapp M.D.

RESULT
CLIN PATH URINALYSIS
SP GR 1.001 MICRO 16 04 Oct
PH 5 WBC 0-1
ALB O RBC 2-4
GLUCO CASTS
ACET O Mod Epith.
4+ Bacteria
CLIN PATH Few yeast.

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

6578

218 12 40

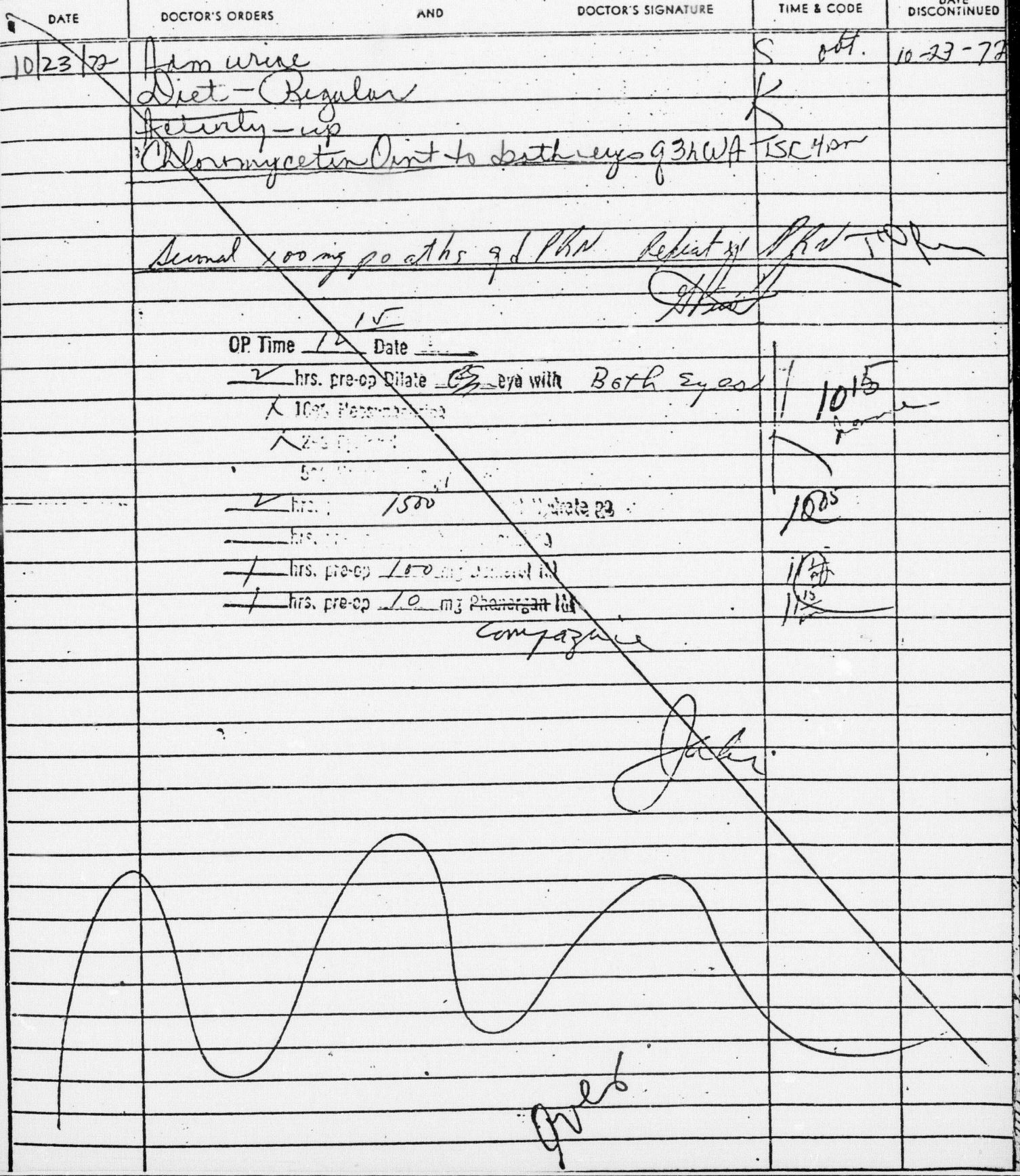
JOHNSON ANNA

09-17-32 F

308-1

DOCTOR'S ORDERS

DATE	DOCTOR'S ORDERS AND DOCTOR'S SIGNATURE	TIME & CODE	DATE DISCONTINUED
10/23/72	Am urine	S ort.	10-23-72
	Diet - Regular	K	
	Activity - up		
	Chloromycetin Oint to both eyes q3hWA	TSC 4 hrs	
	Seconal 100 mg po at hs q d PRN Refill x1	PRN	
	OP Time 1500 Date 10/23		
	2 hrs. pre-op Dilate both eyes with Both Eyes	1015	
	X 10% Phenylephrine		
	X 2½% Cyclogyl		
	5% Neo-Synephrine		
	2 hrs. 1500 Demerol 75	1005	
	hrs. Vistaril 50 mg		
	1 hrs. pre-op 1500 mg Solucortef IV		
	1 hrs. pre-op 10 mg ~~Phenergan IM~~ Compazine		



679 218 12 40
JOHNSON, ANNA
09-17-32 F #1
308

DATE	DO	TIME & CODE	DATE DISCONTINUED
		FOR NURSES' USE ONLY	
10-24-78	Operation Valium 5mg I.V. (Dr. Knapp - ORL)	12 45 pm	
	1. Gastrin 0.45 mg up BEPc	K.	
	2. Aspirin 600 mgm. p.c. & h.s. P.R.N.		
	~~3. Codeine 60 mgm. p.c. & h.s. P.R.N.~~		
	~~4. Dalmane 30 mgm. h.s. P.R.N.~~		
	~~Phenobarbital 400 mgm. h.s. P.R.N.~~	30 Cpm	10/26
	Seconal 100 mgm. h.s. P.R.N.	F.V. 10-10/25 OK F.V.	D/C 10/26 FOOT
	~~Demerol 75 mgm. q 3 h. P.R.N.~~		
	~~Vistaril 50 mgm. q 4 h. P.R.N.~~		
	Milk of Mag. 30 cc. q.i.d. P.R.N.	Tok F.V.	
	Ativan		
10-26	Cancel Intramedic Librium Sshyn tab. 25 mg. i. Knapp	done 9 pm KM	10/26 2pm
10-27	Dalmane 30 mg. as directed daily Should at night Knapp	9 30 pm	
10-28	Neosporin Oint. q.h.s. to R. ear Ativan 1 mg. i.m. q 4 h. P.R.N. Allow Telephone Knapp	TS 9 PM K.	
10/30	Chloramphenicol Opht. gtts. w/c to right eye	TC 10 AM	

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

1 373 680 218 12-40
EI SE JOHNSON ANNA
308-1 09-17-32 F

DOCTOR'S ORDERS

FOR NURSES USE ONLY

DATE	DOCTOR'S ORDERS AND DOCTOR'S SIGNATURE	TIME & CODE	DATE DISCONTINUED
	OP Time 10 30	8:30 am	
	2 hrs. pre-op Dilate OD eye with		
	10% Neosynephrine		
	2% Cyclogyl		
	5% Homatropine	8:30 am	
	2 hrs. pre-op 100 mg Chloral Hydrate po		
	hrs. pre-op mg Seconal po		
	1 hrs. pre-op 100 mg Demerol IM	9:30 AM	
	1 hrs. pre-op 50 mg Phenergan IM		
	& Surpazine		
	E Wadner		
10-31-72	Observation	10:35 am	
10-31-72	Valium 5mg po now (Dr. Swanton RN)		
	1. Gatch 45° ..... Allow up ... tomorrow	with help K	
	2. Aspirin 600 mgm. p.o. q. 4 h. P.R.N.		
	~~3. Sedine 30 ..... mgm. p.o. q. 4. h. P.R.N.~~		11-2-72
	~~4. Demerol 50 ..... q. 4. h. P.R.N.~~	2:45 p	11-2-72
	5. Seconal 100 mg po HS	8:30 pm	
	M. Green		
11-1	~~Novocaine 1% 1 cc~~	ISC 10am	11-3-72
	~~Solu-Cortef 100 mg I.V.~~		
	~~Lidocaine 5 mg/cc I.V.~~	TC OK prn	
	Cardiofax		
11-2	Allow telephone - Schaffer	K	

NEUROLOGICAL INSTITUTE

273

218 12 40

681

= 3E JO

= 908-1 09- ANNA

32 F

DOCTOR'S SIGNATURE	FOR NURSES' USE ONLY: TIME & CODE	FOR NURSES' USE ONLY: DATE DISCONTINUED
	K Temp. here 11/3	
	K SC 10 AM	

11-3 ~~pt is dancing day~~ ~~held O.D at night~~ ~~refer done 11/10 pt. 1~~ 1-d. O.D. Knopf

11-7 Clear home Knopf

DAY

250

200

150

100

50

0

80

50

40

30

20

10

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

TEMPERATURE CHART

689 213 12 40
JOHNSON ANNA
09-17-32 F
3 DE

1972

DATE Oct DAY OF ILLNESS 23 24 25 26 27 28 29

B.P. PULSE TEMP C F

250 150 41° 106°
200 140 105°
150 130 40° 104°
100 120 103°
50 110 39° 102°
0 100 101°
RESP 80 90 38° 100°
50 80 99°
37°
40 70 98°
30 60 36° 97°
20 50 96°
10 40 35° 95°

OR

W 114 1/2

B/P 155/100

12 MN. - 12 MN.	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT
P.O.														
P.R.														
SUBCUT.														
INTRAVEN.														
OSTOMY														
TUBE														
URINE														
TOTAL														

STOOLS | RECTAL TREATMENTS

PROGRESS BED - CHAIR - ETC.

DIET

Up as OK Regular

DANA W. ATCHLEY MEMORIAL BUILDING - THE EDWARD S. HARKNESS EYE INSTITUTE - MARY HARKNESS UNIT - NEUROLOGICAL

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683

MEDICATION RECORD

WEEK NO. 1

Medication Dosage, Frequency & Route	Time	Date — Nurses Initials in each Column 23	24	25	26	27	28	29
Chloromycetin oint	12-8		HB					
Both eye q3h w/a	8-4	HPT KP						
	4-12	S						
Seconal 100mg po hs prn Yhx1		10:30 BHB						
Chloral Hydrate 1500 mg PO	10:15	→	F.V.					
Demerol 100 mg IM	11:15	→	F.V.					
Compazine 10mg IM	11:15	→	F.V.					
10-24-72				OR				
Seconal 100mg po q4h prn			8:30p BHB					
Asprin 600mg po q4h prn			8:30p BHB		5:40 MW	5:45		
Thorazine 400 mg po tid	10			MW	$			
	2			MW				
	6			EA				
Seconal 100mg po on hs prn repeat x 1 prn				10pm EA	10:30 BHB	9:30 BHB	10pm BHB	
Librium 5mg PO tid	10					KP	ES	ES
	2				MW	KP	ES	ES
	6				BHB	BHB	BHB	BHB

Nurses Initials & Signature

BHB Thelma B Hall

KP-Kathleen Pappagallo

MW - Marilyn Weis

F.V. Florencia Valdez

EA Esther Arias

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

173 6 84 218 12 48
EE JOHNSON ANNA
09-17-32 F

MEDICATION RECORD
(CONTINUED)

Medication Dosage, Frequency & Route	Time	Oct 23	24	25	26	27	28	29
Neo Decadron gtts to Left Eye TID	12-8							mm
	8-4						2P FV	F.V.
	4-12						EA	EA
Milk of Mag. 30cc po HS, prn								11 AM EG

Nurses Initials & Signature

F.V. Florencia Valdés

EG Esther Granda
EA Esther Arequa
mm Dawn Mc Mag

DANA W. ATCHLEY PAVILION — THE EDWARD S. HARKNESS EYE INSTITUTE — NEUROLOGICAL INSTITUTE

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

TEMPERATURE CHART

Nam .. 685 218 12 4
Unit
Loca JOHNSON ANNA
3 of, 09-17-32 F

Oct-1972.

DATE	10/30		31		11-1		2		3		4			
DAY OF ILLNESS														
12 MN. – 12 MN.	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT
P.O.														
P.R.														
SUBCUT.														
INTRAVEN.														
OSTOMY														
TUBE														
URINE														
TOTAL														
STOOLS RECTAL														
TREATMENTS														
PROGRESS BED - CHAIR - ETC.														
DIET	REGULAR													

MEDICATION RECORD 686

WEEK NO. 2

Medication Dosage, Frequency & Route	Time	Date — Nurses Initials in each Column						
		10-30	31	11-1	2	3	4	5
[illegible]	10	KP						
	2	KP						
	6	BMB						
[illegible]		[illegible]						
[illegible]	12-8	[illegible]	[illegible]					
[illegible]	8-4	F.V.						
	4-12							
[illegible] ointment to [illegible] q 3h W/A.	12-8		[illegible]					
	8-4	10 pm F.V.						
	4-12							
[illegible] Hydrate 1500 mg PO	8 30 am	→	F.V.					
[illegible] 100 mg Im	9 30 am	→	F.V.					
[illegible] 10 mg Im	9 30 am	→	F.V.					
31 → 32				→ OR ←				
[illegible] 50 mg Im q 4h			2 pm F.V.					
[illegible] 100 mg					10 pm		10 pm	10 pm
[illegible]								
[illegible] 5 mg PO	10				KP	KP	MW	MW
[illegible]	2				KP	KP	MW	MW
	6			BMB	[illegible]	BMB	[illegible]	[illegible]
[illegible] gtts (L)	12-8				[illegible]	[illegible]	[illegible]	LB
[illegible]	8-4	KP			FV	Both eyes FV	UR	UR
	4-12				BMB	CA	[illegible]	[illegible]

Initials & Signature	
KP	Katherine Pappagallo
BMB	Barbara Bellew
MW	Marilyn Weiss
UR	Ursula Rich
FV	Florencia Valdés
JB	Jackson
CA	Esther Acheson

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

L 373 687 218 F2 40
EI 33 JOHNSON ANNA
09-17-32 F

MEDICATION RECORD
(CONTINUED)

Medication Dosage, Frequency & Route	Time	Date 6/7 Nurses Initials in each Column					
		30	31	1	2	3	4
Aspirin 600mg po q 4 h prn					10 5A 24		

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

TEMPERATURE CHART

Nov '32

L 373 688 218 12.40
EI BE JOHNSON ANNA
09-17-32 F

WEEK NO. 3

DATE				6			7			8			9			10			11			12		
	DAY OF ILLNESS																							
PULSE	TEMP C	TEMP F		4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12
		106°				13			14			15			16			17			18			19	
150	41°					6			7			8			9			10			11			12	
140		105°																						
	40°	104°																						
130																								
120		103°																						
	39°	102°																						
110																								
100		101°																						
	38°	100°																						
90																								
80		99°																						
	37°																							
70		98°																						
60	36°	97°																						
		96°																						
50																								
40	35°	95°																						

12 MN. – 12 MN.	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT	INTAKE	OUTPUT
P.O.														
P.R.														
SUBCUT.														
INTRAVEN.														
OSTOMY														
TUBE														
URINE														
TOTAL														

TOOLS | RECTAL TREATMENTS

PROGRESS
BED - CHAIR - ETC.

DIET R.A. VAR

689

WEEK NO. 3

MEDICATION RECORD

Medication Dosage, Frequency & Route	Time	11/01 '77 Date — Nurses Initials in each Column 6	7	8	9	10	11	1
Nadolol 40mg PO QHS	12-8	MB	MB					
TID Before Meals	8-4							
	4-12	BMB						
Librium 5mg PO TID	10	MW						
	2	MW						
	6	EA						
Lasix 40mg PO QAM								
Digoxin 0.25mg PO QAM								

Nurses Initials & Signature

MB Shelma Bell

MW Marilyn Wess

BMB Bessie Mae Brown

EA Esther Adiguo

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

NURSE'S NOTES

690

218 12 40
JOHNSON ANNA
09-17-32 F

HOUR	DATE 10/23
	Admitted to Eye 308-1 Dr. Knapp Diagnosis Cataract Both eyes , Denture
	1st adm. Heart Lungs Liver } Neg Kidneys Diabetic Regular diet Denies past ovsed allergies to purjuice by States she will be having menses soon Vision OS-poor OD. good MWeiss
	OCT 24 1972
	Pt feels good. No complaint MWeiss
3pm	Pt voided feels ok.
4-12	Satisfactory post op. evening. Dsg dry & intact. Taking fluid freely. Voiding q s. Arequin

HOUR	DATE OCT 25 1972
	OCT 26 1972
2:30p	Pt states she woke up and hit operated eye & her hand. Crying. Says she has small amt. pain. Dr. Knapp notified. Told nurses to instruct pt. to calm down and he will see pt. later this afternoon. MWeiss
	OCT 27 1972
4-12	Good evening. Shield on for sleeping DTSchramm
	OCT 28 1972
8-4	Comfortable morning. Nothing special about her. Chiedozi
	OCT 29 1972
8-4	Comfortable day. Chiedozi

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F5

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

691 M

ADMISSION AND DISCHARGE SHEET

PATIENT'S FIRST NAME	MIDDLE	LAST	UNIT NUMBER
ANNA	R.	JOHNSON	218-12-40

ADDRESS: 217 SPORT HILL ROAD — APT. HOW LONG THERE?:

CITY: EASTON — STATE: CONN — ZIP CODE: 06425 — AREA CODE TEL. NO: 203-372-5438

AGE	BIRTHDATE: MONTH	DAY	YEAR	CIRCLE: MALE / (FEMALE)	SINGLE / (MARRIED) / WIDOWED / SEP. / DIVORCED
40	09	17	32		

FATHER'S FULL NAME: JOHN — (DEC.) (LIV.)

HUSBAND'S OR WIFE'S NAME: ROBERT — (LIV.) DEC.

MOTHER'S FULL MAIDEN NAME: CAROLINE — (DEC.) (LIV.)

RACE & NATIONALITY: WHITE/AMERICAN

BIRTHPLACE	YEARS IN U.S.	IN N.Y. STATE	IN N.Y. CITY
BRIDGEPORT, CONNECTICUT	40		

TEMPORARY OR FORMER ADDRESS

OCCUPATION	RELIGIOUS PREFERENCE	SOCIAL SEC. NO.
HOUSEWIFE	PROTESTANT	064-25-0975

LOCATION	SERV.	CLASS	DOCTOR	ADM TIME AND DATE
E 0 3681	OPHTH	Semi-Private	Dr. Knapp	10/23/72 @ 1 PM

Disch. Date and Time: NOV 7 1972 9:30 AM

Clinic Appointments

Reportable Diseases (See House Staff Manual) – TBC (T252) – Date Reported

VD (417V) – Date Reported — Other (395V) – Date Reported

Wound Infection – yes no irrelevant (Describe below) — Date of return to work or school — undeterm. irrelevant

Discharge Diagnoses and Operations

Dx Cataracts
10.24 Intracapsular Cataract extraction
& periph iridectomy OS
10.31 Extracapsular cataract extraction
& iridectomy OD

H.I

Signed P. Knapp MD

Additional Pathological Diagnoses

Signed MD

THE PRESBYTERIAN HOSPITAL
IN THE CITY OF NEW YORK
AT
COLUMBIA-PRESBYTERIAN MEDICAL CENTER

SUMMARY

Name
Unit No. 699
Location

Age

Married lady with
Recurrent ulcers of both
eyes after past 2 years

O.D. Intracapsular cataract
ext = primitive reduction
OS

O.S. Intracapsular cataract
ext = primitive reduction
O.D.

1-7 Post operatively O.S. has
cleared satisfactorily
but O.D. shows
striate keratitis of upper
half of cornea.
Discharged home.

[illegible]

Signature of House Officer

Signature of Attending

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JOHNSON, MRS. ANNA (Robert K.)
~~109 Wheeler Road~~
~~Monroe, Conn. 06468~~
217 Pent Hill Rd
Easton, Conn 06425
203 268-6578

Ref: James Garrity M.D.
Age ~~40~~ 38 (9/17/32)

6/19/70 V.O.D. sc. 20/25=
V.O.S. sc. 20/60+ reads 20/30 ±

O.D. +1.00 20/25=
O.S. +1.50 20/30= reads 20/30 ±

Ext & ant segs OK
T.O.U. #13 Neo

Posterior subcapsular plaques
Vitreous clear
Fundi healthy

℞ Recheck 6 mos.

General health fine
No HBP
No diabetes

Felt 2 years ago something was wrong.
Went to doctor but he didn't tell her - was to tell her husband but forgot.
Went to another doctor in February and was told of cataracts.

11/18/70 V.O.D. sc. 20/25-
V.O.S. sc. 20/60 reads 20/30 ±

O.D. +1.00 No help
O.S. +1.50

Px: OK except some lens opac.
T.O.U. #12
℞ None
Sept.

9/15/71 V.O.D. sc. 20/25=
V.O.S. sc. 20/80 reads 20/30=

O.D. +0.50 20/25
O.S. +1.50 20/~~40~~ 30

Px: Some
Rx: 1 yr 505

9/18/72 V.O.D. sc. 20/60 +1
V.O.S. sc. 20/400

O.D. +0.75 20/30- a light ↓
O.S. +1.50 20/400

add +1.75
O.D. reads 20/30-

Ext & ant segs OK
T.O.U. #15 Neo
PSC opacs, more O.S.
Fundi: O.D. OK
O.S. dimly seen
℞ Plan O.S. cataract extraction
Then O.D. one week later.

Much worse.
Unable to read newspapers.

It's Cataract #2

JOHNSON, MRS. ANNA 694

ANNA 11/14/72

10/24/72 OPERATION: Intracapsular cataract extr. with periph. iridectomy O.S. (enzyme & cryo)

10/25/72 Mod p.o. reaction and central striate.
A C formed & clear
Pupil O.K.
1% atrop & Neocort.

10/26/72 Getting jittery & upset -
Switched to Librium from Equanil
Eye O.K.

10/27/72 Sl redness & swelling

10/28/72 Cornea A C & pupil clear
Neodec t.i.d.

10/30/72 O.S. O.K.
10.31 OPERATION: Intracapsular cataract extr. with periph iridectomy O.D. (some bl. in A C)

11/1/72 Mod p.o. reaction
Cornea A C & pupil O.K.
1% atrop. & Neocort.

11/2/72 Temp. lens +11.00 Red

11/3/72 Doesn't see well for near.
℞ O.D. striate
O.S. clear.
Rech. in office re gl. on Monday.

11/4/72 Same
O.S. cloudier

11/6/72 V.O.S. c gl 20/60=
Retinoscopes more plus but no improvement.
O.D. dense striate & thickening above.
Hyoloid bulge but no contact.
O.S. Injected temporally.
Cornea: clear
flare - some R B C's below
Hyoloid intact
Some haze but
Int. O.K.

11/7/72 Less striate O.D.
O.S. clear again
HOME on Hyoscine daily & Maxitrol q.3.h.
November 14, 1:45 p.m.

JOHNSON, MRS. ANNA

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11/14/72 V.O.D. c gl 20/100
V.O.S. c gl 20/60-2
O.S. +11.00 +1.50 X20 20/60+2
Ext: Injected, mild striate O.D.
Int: O.K.
Stop Hyoscine.
℞ Use Maxitrol q.3.h.
1 wk.

Awakens with bad frontal headaches. Turns out only using hyoscine.

11/21/72 V.O.D. +11.00 +2.00 X5 20/30-
(not refined)
V.O.S. +11.50 +1.25 X45 20/25-1
Mild injection
O.S. sl haze & thickness of cornea above.
sl strand to incision at 11 O.S.
Int: O.K.
℞ Hyoscine q.2.d.
Maxitrol 4 x d
2 wks.

Much better.

12/5/72 O.D. +10.75 +1.50 x 22 20/30=
O.S. +10.50 +2.00 x 25 20/30-

Px: Mild dry injection
Corneas clear
AC + - flare
Hyaloids intact
Fundi OK

℞ Econopred 4xd O.U.
2 weeks

12/19/72 Peculiar trouble seeing - needs to look up or turn head so hard to refract x 2

Px: No gross reason seen for ↓ V.A.
℞ Cont. drops t.i.d. 1 week & try again

12/21/72 PHONE Husband phoned ?cause of Tuesday exam
℞ Don't know but try again

12/26/72 O.D. +13 +2.50 x 170 20/60+2
O.S. +11.75 +1.25 X 20 20/25-

Hyoscine & atrop etc O.D.
O.D. +10.50 +3.00 x 28 20/30-

Px: Ext: sl. injection above
O.D. sl. opac on back of cornea above
AC's clear
Hyaloids intact
T.O.U. #13
some central vitr. haze O.D.
Retina OK
O.S. OK

JOHNSON, MRS. ANNA

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1/9/73 O.D. +12.00 +3.00 X6 20/100
O.S. +12.50 +1.00 X160 20/60
Px: # flare --mild injection.
T. OU #16
CYCLO Neo & Hyo
Mild vitr haze O.D.
Fundi: Mild edema of macula O.U.
℞ Econopred 4 x d
1 wk.

Vision 3 days ago - assoc. with menstrual period.

1/16/73 O.D. +12.25 +3 +6 20/80-1
O.S. +12 +2 x 155 20/40-1

Has a cold so O.D. cloudy

Ext & ant segs OK
Int: Mild edema of maculae present
℞ Cont. Econopref 4xd.
2 weeks

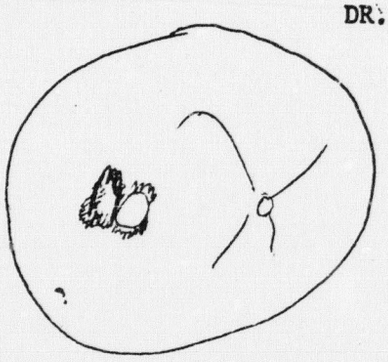
1/30/73 O.D. +10 +2.50 x 25 20/60-2
O.S. +11.25 +1.75 x 10 20/40-2

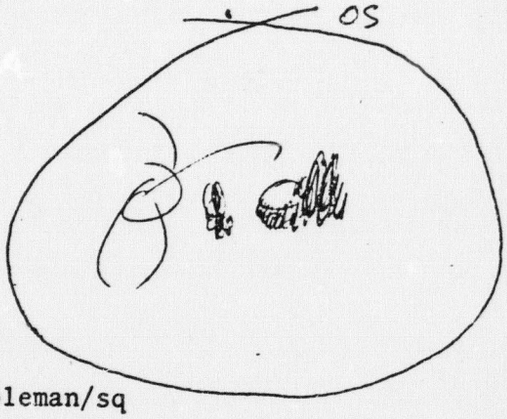
F T. soft, normal
Ant segs quiet, O.U.
Maculae: unchanged

℞ Cont. Econopred ½ i.d.
2 weeks

February 22, 1973
I,V. Fluro.

DR.





Leadages OU. Rec: Argon Laser OD & OS.

Dr. Coleman/sq

2/22/73 Things clear today. OD: + 12 + 3 x 170 to 20/20
OS: + 11 + 1.50 x 20 to 20/80+

External: OD
Ant. Seg. Curved line above
TOU 16 Neomydr and atropine
OU Edema of Maculae.
Rx: To Dr. Coleman for angiography.

Dr. Knapp/sq

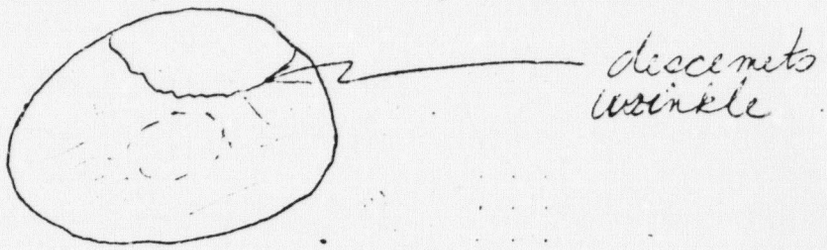
February 27, 1973
Argon laser Rx OS to area temporally inferior and same nasal to macula
OD cornea not clear and Rx deferred.
2% cyclogyl OS TID x 3 days
Return 2 weeks.

Dr. Coleman/sq

JOHNSON, MRS. ANNA

6 94

March 5, 1973
Left eye clearing
OD: cornea hazy. Has 2+ endothelial edema, with linear change in descemets



Tension OD 16
OS 10 (A)
Fundus: ⊖ good Rx forming OS macula. No complications.
Impression? endothelial dystrophy OD
No Rx: Return 2 weeks.

Dr. Coleman/sq

March 19, 1973
Sees better with OD - Cornea unchanged
Vision OD 20/200
OS 20/50
Contac helped
Continue with no drops.

Dr. Coleman/sq

April 16, 1973

Right eye feels like a "pressure"

c p.r. Vision O.D. 20/20c
O.S. +10.50 +2.00 x 25 → 20/40 ± 1

Tension O.D. 19, O.S. 9 by applanation

Cornea O.D.: 3+ haze c shagreen-curved descemet's wrinkle remains.
Fundus (not dilated):
O.D. not well seen due to edema
O.S. macula pigment doing well -
appears dry, has strand of - - - -
at 9 o'clock margin of - - -

IMP: O.S. doing well

Dr. Coleman

4/16/73 Px: O.D. injected
Cornea: Epithelial bedewing c peculiar color.
Same curved line on back of cornea above.
T.O.U. #11
Int: Murky, so barely get red reflex.

℞ Econopred q.3h.
1 week

/25/73 O.D.: No reflex No pain
Less injected, less bedewing and
less haze.
T. #12
O.S.: Clear
T.#11
℞ Same
2 weeks

... ANNA JOHNSON

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5/8/73 O.D. almost a shadow < 20/400
O.S. +12.25 +0.50 x 180
20/30-

Px: O.D.: white
sl. hazy cornea c +flare
No change line above
T.O.D. #13
T.O.S. #11 (squeezes)
O.D. hazily OK
O.S. clear
sl. macular change
℞ Drops t.i.d. O.D.
2 weeks

5/24/73 O.D.: No shadow
Bedewing of epith
Some haze in pupil below
Int: Hazily OK
T.#11 squeezing

O.S.: +12.25 +0.75 x 5
add +3.00

℞ Hyoscine daily O.D.
Econopred q.3h.
3 weeks

/14/73 O.D. Faint shadow
O.S. +12 +1.00 x 5 20/30-

Px: Bedewing of epith O.D. c same
thick line above
O.S. clear
T.O.U. #10
Int: Hazily OK O.D.
OK O.S.
℞ Epinal b.i.d. O.D.
Econopred 4xd.
3 weeks

Authorization to release information given 11/8/73

2/7/73 Mr. Richard Lutz. Wanvig Inc., said to just write a note to claim Dept. & explain the details of Mrs. Johnson's case as far as you are concerned.

2/18/73 Miss Boyle Emp. of Wausau 984-2458

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Dr. Knapp - 10/6/72

You will be operating on my wife's eyes next week. I think you should know she is somewhat on the "high strung" side. After the operation you may want to prescribe something to keep her settled.

Robert K. Johnson

T's Exhibit #9

BEST COPY AVAILABLE

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Philip Knapp, M.D.
Institute of Ophthalmology
635 West 165th Street
New York, N.Y. 10032

POST-OPERATIVE INSTRUCTIONS FOR CATARACT EXTRACTION:

Dissolve 1 teaspoonful of table salt in a pint of boiling water. Cool and use with cotton to clean lids morning and night before using fresh medication.

Wear dark glasses or own glasses during the day, shield at night.

DO NOT BEND, STRETCH, LIFT ANYTHING HEAVY, or STOOP.

DO NOT WASH HAIR OR TAKE A SHOWER.

Use medication as noted below.

If in doubt about doing anything, DO NOT DO IT.

Re-check in office on _____.

Pl's Exhibit #10

ummary on Mrs. Anna Johnson

701

7/11/73

rom: Dr. Knapp
o: Dr. DeVoe

0/24/72 Operation O.S.: Intracapsular cataract extraction
with peripheral iridectomy (cryo and enzyme)

0/31/72 Operation O.D.
Some blood in anterior chamber

Post-operative striate keratitis O.D.

1/21 and 12/5/72
V.O.D. cc. 20/30

V.O.S. cc. 20/25

an'73 Macular edema (*rvine - Goss)

eb'73 Fluorscein leakage O.U.

so referred to Dr. Coleman for laser.

O.S. done but O.D. deferred due to haze;
he thought endo dystrophy.
Worried re fungus so stopped local steroids.

O.D. got red and murky plus corneal edema
so re-started local steroids in April.

Since then, inflammation down but edema persists.
Opacity on back of cornea O.D. since one month post-op.

7/11/73 Appt. canc. by mail:

T.D. Exhibit # 11

702

June 22nd, 1970

James Garrity, M. D.
292 Elm Street
Monroe, Conn.

Dear Dr. Garrity:

On June 19th, I examined your patient, Mrs. Anna Johnson. She does have early cataracts that are only unusual by their appearing in a person of her age. There is no way of judging their rate of progression so I asked her to come back in the Fall.

Thank you for referring her.

With kind regards,

PHILIP KNAPP, M. D.

PK:am

Pl's Exhibit #12